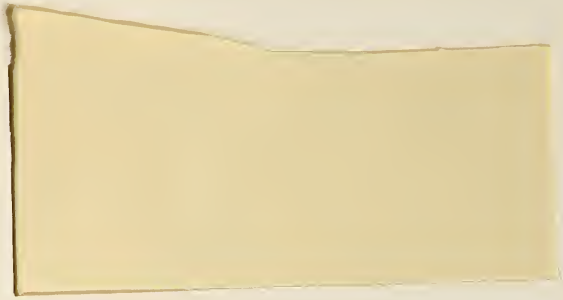
Information
Resource

MEDICAID AND PRIMARY CARE NETWORKS

State Medicaid
Information Center

REPORTS
R
729
.5
G4
N43
1981

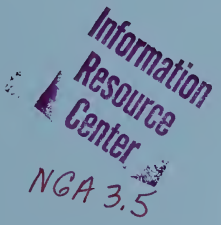
Center for Policy Research
National Governors' Association



R
729.5
.G4
N43
1981

MEDICAID AND PRIMARY CARE NETWORKS

A Concept Paper and the Proceedings
of the NGA Conference on Medicaid and
Primary Care Networks/Case Management Systems
December 2, 1981



State Medicaid Information Center
Center for Policy Research
National Governors' Association
444 North Capitol Street
Washington, D.C. 20001
202/624-5354

March 1982

TABLE OF CONTENTS

Introduction iii

Medicaid and Primary Care Networks: A Background Paper
- Bruce Spitz vii

Panel 1: Private Sector Experience with Primary Care Networks (PCNs). 45

Safeco's United Healthcare - Roswell Bond 47

Wisconsin Physician Services - Paul Simenstad 53

Group Health Plan of Northeast Ohio - Maxwell Davis 59

Middle Georgia Medicalcare - Frank Evans 69

Question and Answer Session 73

Panel 2: Experience of Primary Care Networks Serving an Indigent Population . . 83

Group Health Plan of Northeast Ohio
- David Schmidt 85
- John Abramson 89

Multicare of Multnomah County, Oregon - Becky Belangy 97

Massachusetts Medicaid Care Management Program
- Dennis Beatrice 103

Question and Answer Session 115

Panel 3: What States are Doing to Implement Primary Care Networks. 125

Maryland - Lyda Sanford 127

Michigan
- Sherry Wellman 147
- Bruce Hansen 151

Question and Answer Session 157

Conference Summary - Vernon Smith 163

Appendices

I. Conference Agenda 169

II. Physician-Based Group Insurance, Frank Evans, Milledgeville, Georgia. . . 173

III. Primary Physician Sponsor Plan, Michigan Medicaid Program 177

INTRODUCTION

It is widely recognized that public and private health care financing programs have been unable to control rapidly rising health care costs and to reduce the unnecessary use of expensive treatment modalities. As a result, purchasers of health care have faced significant cost escalation and a commensurate decline in the purchasing power of their dollar.

The Medicaid program has not been immune to these problems. As with all fee-for-service third party payment mechanisms, neither Medicaid providers nor recipients have incentives to utilize services only when necessary or in the most cost effective setting. The program has historically displayed a bias toward costly institutional care, as it is often easier and more lucrative for physicians to care for their patients in an inpatient setting. Further, Medicaid recipients must frequently obtain ambulatory care in expensive outpatient hospital departments or emergency rooms because low Medicaid payment rates and paperwork discourage physician participation. The worsening fiscal situation at the state level has compounded the financial impact of these problems for state Medicaid agencies.

Unfortunately, most health care cost containment efforts, with the major exception of the health maintenance organization (HMO) concept, have attempted to control costs without altering the basic incentives which affect provider--particularly physician--decisionmaking within the marketplace. However, a relatively new health care financing and delivery structure--the primary care network (PCN)--has significant potential to improve those incentives. In general, the PCN increases the responsibility of the primary care physician for the overall management of his/her patients' care, largely by making the physician more aware of the financial implications of his/her decisions.

While no single strategy offers a panacea for the Medicaid program's problems, the primary care network model has greater potential to successfully address a broad range of these problems than perhaps any other policy option. It is hoped that primary care networks will be able to:

- Establish accountability for Medicaid costs;
- Improve client access to ambulatory care in cost-effective settings (by reducing red tape and paperwork and increasing reimbursement for physicians);
- Reduce unnecessary use of costly services and settings;
- Improve the continuity of care for Medicaid recipients.

Further, the primary care network model does not require the establishment of a new administrative apparatus by providers--it uses existing primary care physicians and can be implemented in urban or rural settings. And, unlike the prepaid health plans in California in the early 1970s, it can be structured with only limited risk-sharing to avoid fiscal incentives to providers to deny needed care. In recognition of the potential such an approach might have for slowing the rise of Medicaid expenditures, the U.S. Congress, in Section 2175 of P.L. 97-35 (the Omnibus Budget Reconciliation Act of 1981), provided waiver authority for the states to establish or contract with "primary care case management systems" through their Medicaid programs.

Unfortunately, very little information has heretofore been available concerning the implementation of the primary care network model. In an attempt to fill this void, the National Governors' Association's State Medicaid Information Center commissioned a paper which would explore the conceptual basis and operations of PCNs. In addition, NGA sponsored a one-day conference on primary care networks in December 1982. The conference was structured to meet the information needs of state Medicaid policy makers and administrators interested in exploring the PCN option. The objective was to provide answers to those questions most relevant to these state officials:

- What are the conceptual underpinnings and key elements of primary care networks?
- Are there different structural or organizational models of PCNs?
- What has been the organization and experience of PCNs serving the general population?
- What has been the organization and experience of PCNs which serve a low-income or Medicaid population?
- What is the potential for utilizing PCNs within state Medicaid programs?
- What specific issues must a state Medicaid agency address if it wishes to establish or contract with a PCN for the care of its Medicaid recipients?
- Which states are actively planning to utilize the PCN concept within their Medicaid programs and what will be the design of their approaches?

To address these questions, NGA brought together as presentors the leading experts on the topic: plan administrators, providers, and state officials who have either had direct experience with the operation of PCNs or who have been involved in their planning and development. The result was an exciting meeting which interwove discussions of conceptual issues with the exchange of nuts-and-bolts "how to" advice among program administrators interested in experimenting with PCNs.

The organization of this document follows that of the conference. Presented first is the PCN concept paper which was summarized at the conference and includes brief descriptions of those PCNs discussed in greater detail by the other conference participants. Following are three panel sessions which addressed each of the following topics:

- private sector experience with PCNs;
- the experience of PCNs caring for an indigent population; and
- selected Medicaid agencies' plans for implementing PCNs.

Each panel presentation was followed by a question and answer session. The transcript of each of these sessions is included after the appropriate set of presentations.

The efforts of a large number of individuals accounted for the success of the NGA Conference on Medicaid and Primary Care Networks. We are grateful to Bruce Spitz for his excellent paper on PCNs which served as background document for the conference. We are also indebted to the other conference presentors: Ros Bond, Paul Simenstad, Maxwell Davis, Frank Evans, David Schmidt, John Abramson, Becky Belangy, Dennis Beatrice, Barbara Matula, Lyda Sanford, Bruce Hansen, Sherry Wellman, and Vern Smith. Those who benefited from the conference did so because of these individuals' knowledge of and enthusiasm for the primary care network issue. Acknowledgement is also due to those attending the conference who participated so actively in the discussions on PCNs. Certainly the presentors' remarks were enhanced by the insightful issues raised during the question and answer sessions. Finally, thanks are due to Irene Zarechnak of NGA who handled the logistics of the conference and who was primarily responsible for pulling together the proceedings.

These conference proceedings are expected to not only expand the number of people able to access the information provided at the conference but to also serve as a valuable resource document for those who attended the conference. It is unfortunate, however, that the written word cannot fully convey the energy and excitement of the actual dialogue between conference participants. Nonetheless, it is our hope that the publication of these proceedings will assist states in exploring the potential use of the primary care network model within their state Medicaid programs.

Richard Curtis
Director of
Health Policy
Projects, NGA

Lawrence Bartlett
Project Coordinator
State Medicaid
Information Center

Office of Research and Development
Center for Policy Research
National Governors' Association

PRIMARY CARE NETWORKS AND MEDICAID
A BACKGROUND PAPER

Prepared by
Bruce Spitz

A synopsis of this paper was presented at the National Governors' Association Conference on Primary Care Networks/Case Management Systems, New Orleans, Louisiana, December 2, 1981.

The preparation of this document and the Conference on Primary Care Networks are made possible by a grant from the Office of Research, Demonstrations, and Statistics (ORDS), Health Care Financing Administration, Department of Health and Human Services to the National Governors' Association (HCFA Grant #18-P-97923/3-01).

ACKNOWLEDGEMENTS

Primary care networks are a recent development. An extensive literature on networks does not exist. Fortunately there are a number of very bright and enterprising individuals who are studying, developing, administering or practicing medicine within primary care networks. A number of these individuals have graciously shared their obversations and time with me. I would particularly like to thank Stan Sells, Cathy Taylor, Bruce Hessing, Max Davis, Frederick White, Jake Epstein, David Schmidt, John Abramson, Steve Zyzanski, Vern Smith, Bruce Hansen, Sherry Wellman, Frank Evans, Frank Sloan, Paul Simenstad, John Cirn, Joan Trauner, Becky Belangey, Ross Bond, Robert Gregory, Diane Martin, Lyda Sanford, Martin Royscher, Lawrence Clark, Dorothy Sherman, Janet Fink, Jim Smid, Dennis Beatrice, Diane Nassiff, Tristam Blake, Maechael Winston, Langdon Burwell, Richard Froh, Roger Graham, Sidney Trieger, Bruce Stienhardt, Wendy Zinn and Steven Zinn.

Two individuals warrant special acknowledgement. I wish to thank Richard Curtis, the Associate Staff Director for Health Policy at the National Governors' Association for anticipating the need for this paper, convening the primary care network conference, commissioning the study and contributing his observations and criticisms on the paper. I would also like to thank Larry Bartlett, Coordinator of the National Governor's Association's State Medicaid Program Information Center, for his critical reviews, clarity of thought, editorial contributions and support.

TABLE OF CONTENTS

	Page
I. Background Medicaid Cost Containment	1
II. Primary Care Networks: What Are They?	2
A. Advantages of PCNs	6
B. Disadvantages of PCNs	8
III. Examples of Primary Care Networks	10
A. Health Maintenance Program of the Wisconsin Physicians Service	10
B. Safeco's United Health Care Program	14
C. Group Health Plan of Northeast Ohio	17
1. GHP and Medicaid	20
D. Multicare of Multnomah County, Oregon	21
E. Massachusetts Case Management Demonstration Project	26
F. The Santa Barbara Health Initiative	28
G. The Michigan Physician Primary Sponsor Plan	32
H. Physician Based Group Plan of Baldwin County, Georgia	35
IV. Medicaid Contracts With PCNs	37
A. Eligibility	37
B. Benefit Coverage	38
C. Marketing and Enrollment	38
D. Physician Participation in the PCN	38
E. Case Management	39
F. Quality Assurance	39
G. Reimbursement	40
H. Data Systems	41
I. The State Agency as the PCN	41
Conclusions	42
Footnotes	43

I. BACKGROUND: MEDICAID COST CONTAINMENT

The Medicaid and Medicare programs have contributed to major changes in the health care delivery system. They have increased access to health services, greatly increased public expenditures and made health care cost containment a major public issue. Part of the cost problem for these programs has been that they bought into an expensive and often inefficient fee-for-service system. Thus the cost and utilization experience of the programs inevitably reflected health care cost inflation, growth in esoteric and costly technology, increases in institutional capacity and increases in the intensity of services provided.

Medicare and Medicaid, however, have not passively participated in the changes and trends in health care. The enormous financial resources that these programs have pumped into health care would alone have forced major adjustments in the industry. In addition to this flow of money, however, an enormous amount of regulations and stipulations have been tied to those funds. The Medicaid program has had to work through its own programmatic quirks (some of which were only slightly exagerated forms of fee-for-service quirks). A continually troubling feature of Medicaid has been its strong bias toward institutional care, particularly hospitalization. From the providers' viewpoint it has been easier and more lucrative to place and serve a client in the hospital than in an office or clinic setting. It has also been easier for many clients to seek out and receive ambulatory care in hospital out patient departments and emergency rooms than in physicians' offices. In part, such problems have been due to the fact that clients receive a Medicaid credit card which often made them indifferent to the medical costs incurred on their behalf. It has also been due to the lack of access to primary care providers. Finally, Medicaid's costs also mirror the medical practices of that small portion of the provider population which has specialized in seeing Medicaid clients, dealing with Medicaid regulations and officials, and maximizing Medicaid revenues.

On the whole, the Medicaid financing system has improved access to care for the poor and improved their health. It has also produced doctor shopping,[1] and excessive use of the outpatient departments and emergency rooms[2]. It allows a small percentage of the clients to consume enormous amounts of medical resources,[3] some because of catastrophic illnesses and some because of gross misutilization of the program.[4] Over the years, many states have attempted to address these problems through program changes. Those changes have at times been blocked by federal regulations and effective provider and

client political pressure. The dimensions of the present situation, however, have diminished a great deal of this resistance to change. The rates of increase in Medicaid expenditures, Medicaid's prominence in most state budgets, severe state fiscal problems and, recently, wholesale federal retrenchment, have made Medicaid a prime target for intense cost containment efforts.

Although in the past health care cost containment measures have been presented in a number of forms, they generally fall into two categories: those which tinker with the existing fee-for-service system and those which attempt to construct an alternative to that system. In the early seventies, all alternatives seemed to be subsumed under the generic label of "health maintenance organizations." That broad category, however, fails to adequately describe the experimentation and developments of the past decade. There are a number of hybred solutions to rising medical costs which do not fall neatly into either the fee-for-service or traditional prepaid approaches yet which promise to restructure the delivery of care. The Omnibus Reconciliation Act of 1981 gives states far greater authority to pursue such alternatives.* One of the most interesting and potentially powerful innovations now available to the states is the primary care network (PCN).

II. PRIMARY CARE NETWORKS: WHAT ARE THEY?

In general, a primary care network (PCN) has three characteristics: 1) it consists of primary care physicians disbursed throughout the community in solo or group practices, 2) patients are enrolled in the PCN and assigned to a single primary care physicians, and 3) the network increases control that the primary care physician has over the total medical care received by the patient. At a minimum, this means that patients are discouraged from doctor shopping and self-referral. The primary care physician also acts to review and approve all care. Thus, PCN's can increase the gate keeping function of the primary care physician without altering fee-for-service reimbursement policies.

In their more sophisticated and complex organizational form, PCNs can be very similar to HMOs in which the primary care physician is responsible for both the medical

*Relevant provisions provide statutory and/or waiver authority for states to implement a primary care case management system; to restrict beneficiaries to efficient providers or practitioners, to share with clients savings of cost effective care through additional services, to enter into prepaid arrangements with other entities besides federally qualified HMOs, and to drop providers who generate unnecessary utilization of services from the program.

and financial management of the patients. The network consists of individual or groups of primary care physicians, and is augmented by a panel of specialists selected by the PCN or each primary care physician. Patients are "locked in" to their primary care physician who approves all specialty care. Non-emergency self referrals are not reimbursed. The primary care physician is financially at risk for primary care, specialty care and hospitalization. Reimbursement arrangements, however, may vary. They can be fee-for-service with a percentage of the fee held back to cover costs in excess of targeted amounts. If expenditures are less than expected, these "hold back" funds are distributed at the end of the year as a bonus. Reimbursement can also be a straight capitation arrangement in which the physician receives a predetermined payment for providing services to an enrollee. In either care, the primary care physician reviews and approves all expenditures made on behalf of his patient.

Some confusion has arisen concerning the way in which PCNs differ from a number of related organizations: prepaid group practices (PGPs), independent practice associations (IPAs) and patient "lock-in programs." As indicated in Table 1, PGPs and IPAs are both considered health maintenance organizations and are financed through capitation fees. PGPs, however, restrict physician participation. Typically, a closed panel of doctors is selected, reimbursed on a salary or capitation basis and responsible for providing medical care to those who enroll in the PGP. The IPA by comparison is often open to all doctors within a county or community, the physicians remain in their offices and are reimbursed on a fee-for-service basis. "Lock-ins" usually refer to special programs designed to control abusive behavior by Medicaid clients. States establish unambiguous definitions for excessive utilization, identify clients who have used services in that manner and allow them to select one physician and one pharmacist. Thereafter, the patient can only receive care through the providers he has selected. The lock-ins are often the most undesirable patients to care for in the Medicaid population. As a result, problems often arise finding physicians willing to accept the lock-in responsibility.

As shown in Table 1, PCNs share some of the characteristics of PGPs, IPAs and lock-ins, but differ in their overall configuration. Unlike PGPs, PCNs employ solo and groups of physicians in the community and may reimburse them on a fee-for-service basis. Unlike traditional IPAs, PCNs can be much more demanding of the prospective physicians it will accept into the network and may reimburse them on a capitated basis. And in contrast to lock-in programs, PCNs do not focus on the worst cases in the community and are not wed to a fee-for-service system. Another way of defining PCNs is to think of

them as a subset of independent practice associations, and lock-ins as a subset of PCNs. While the differences among the various structures may at times be subtle, the central role of the primary care physician is the distinguishing characteristic of PCNs. Increased responsibility, risk and control by the primary care physician may be one of the most effective ways that health care can be contained without building a new system from the bottom up or overburdening the existing system with excessive constraints and controls.

TABLE 1
COMPARISON OF ORGANIZATIONAL CHARACTERISTICS

	PGP	TRADITIONAL IPA	PCN	LOCK-IN
Enrollment	Open to groups and select individuals	Open to groups and select individuals	Open to groups and select individuals	Restricted to worst cases
Professional Participation	Selected by PGP, Physician groups, working on-site at the PGP	Open to all solo and physician groups working in their own offices	Solo and physician groups working in their own offices, selected by PCN	Physicians willing to participate
Enrollee Self-Referral	None	Range: None to unlimited	Range: None to limited	None
Form of Physician Reimbursement	Salary or capitation	Fee for service	Fee for service and/or capitation	Fee for service

Most of the PCNs have been organized within the last ten years. Their evolution and growing popularity has been the result of at least three converging trends. The first is Blue Cross/Blue Shield's selective response in the 1970s to an expected challenge by HMOs. By adopting an IPA format, a few Blue Cross/Blue Shield agencies were able to garner both physician and client support. While much of this activity has taken place on the West Coast (e.g., Take Care of Northern California and Healthnet of Southern California), the first actual PCN began in Wisconsin with the Wisconsin Physicians Service. These PCNs are unlike the traditional IPAs which were developed between the 1940s – 1960s and sponsored by county medical societies. Beyond the obvious fact that the sponsors are different, so too is the regulatory environment and goal of these agencies. According to Clark Havighurst, the original IPAs were frequently organized to block the entrance of closed panel HMOs into an area.[5] These IPAs frequently preserved fee-for-service reimbursement, invited all physicians in the county to participate, and acted to preserve a fee-for-service style of practice.

The Blue Shield PCNs do not quite behave in the same way. They impose constraints on their members that IPAs did not. PCN membership criteria is not necessarily open to all physicians. Membership can be highly selective and criteria for participating very demanding. The primary care physician's role is elevated. The client is locked in. And, physicians are financially at risk.

The second trend contributing to PCNs is the growth and acceptance of family practice. It has formally been recognized as a specialty for the past 12 years. The recognition and acceptance of family practice medicine as a specialty has in many ways legitimized the primary care physicians role as manager of his patient and coordinator of the specialists. It should be noted, however, that most PCNs do not limit their definition of primary care physician to a board certified family practice physician. Some accept non-board certified general practitioners. Others extend the definition to internists, obstetricians, gynecologists and pediatricians. Still others permit any physician to designate himself as a primary care physician, although it is unlikely that many specialists such as anesthesiologists or neurosurgeons have done so.

Finally, a number of developments within Medicaid have made PCNs very appealing and prompted some states to begin to pursue their development. The factors contributing to this include: the recurring fiscal problems in Medicaid, the illusive nature and meaning of "mainstream medicine," the questionable application of the "freedom of choice" provision, the institutional biases within the program, the excessive use of outpatient departments and emergency rooms and the growing use of Medicaid lock-in programs which have highlighted the potential of case management with difficult clients. In addition the relative success of the OEO Neighborhood health clinics and free standing clinics supported by "330" money from the Bureau of Community Health services suggests that access to non-institutional ambulatory care can reduce the total cost of care. These projects also offered models for primary care networks. Another factor has been California's ability to overcome its Medicaid prepaid health plan scandals of the early 1970s and develop a tightly controlled and sophisticated HMO program. This may have diminished some of the resistance that states have had to HMOs. Further, since California has developed the organizational format and technology for regulating and monitoring HMOs, other states can import solutions and adopt them to their system rather than starting from scratch. Finally, the increased recognition and acceptance of case management for long term care and acute care led to the changes in the law. The Omnibus Reconciliation Act of 1981 P.L. 97-35, for example, provides states the flexibility to request waivers to establish PCNs.

As these developments have converged, more and more states have considered experimenting with PCNs. California recently passed legislation requiring one or more pilot projects to examine the broadscale application of "primary care case management." Massachusetts is planning to expand their case management and HMO initiatives as well as "explore the possibilities of contracting with a fiscal intermediary which would assume responsibility for a defined Medicaid population and organize the primary care network to serve this population." In Michigan and Maryland, task forces were recently convened to consider PCNs and make recommendations. As a result, PCN demonstration projects are currently being designed in both states.

A. Advantages of PCNs

The development of PCNs, however, should not be construed as the result of an unconscious convergence of trends. There are a number of specific reasons why a Medicaid program might use PCNs.

1. PCNs can reverse expensive financial incentives in the fee-for-service system. The physician's preeminent position in the health care system effectively places him in control of enormous resources. Physicians are responsible for approximately 75 percent of total health care costs although their direct revenues account for less than 19 percent of total expenditures.[6] Further, physicians operate within a delivery system which not only tends to hold them harmless for the financial implications of their medical decisions, but has very strong biases towards specialization, esoteric and costly technology and hospitalization.[7] By making a primary care physician responsible for the medical and financial management of a patient a point of accountability is established. The professional in charge will typically have a less expensive style of practice than the specialists. Finally when the primary care physician is financially at risk for all services provided he then has every incentive to act as a conscientious and useful fiduciary agent for his patient.

2. PCNs constrain patient misuse of the system. Unless federal waivers are granted or a state exercises the power granted it in recent federal legislation to drop abusive providers from its program, Medicaid permits any licensed physician or hospital to participate in the program. Clients can seek out care wherever they wish and at no cost to themselves. This can create two very expensive problems for the Medicaid program. The first is the costly and unnecessary use by the client of the emergency room for non-emergeny medical conditions. In some high volume Medicaid hospitals, 70 to 90 percent

*We recognize that this tendency is constrained by a number of factor's, for example, utilization controls and, for non-Medicaid patients, when insurance coverage is incomplete, the patients' inability to pay physician fees out of pocket.

of the visits to the emergency room were for non-emergencies.[8] These services could have been provided less expensively in a free standing clinic or a doctor's office. The second is doctor shopping or excessive self referral to both primary care physicians and specialists for trivial medical conditions or excessive confirmation of a given diagnosis. By locking patients into a primary care physican and denying Medicaid reimbursement for non-emergency out-of-plan services both problems can be addressed. This assumes that the primary care physician conscientiously performs his management tasks (i.e. he does not approve all self-referral services after the fact) and that the state clearly and unambiguously identifies the client as a PCN member (either through specially marked Medicaid cards or by requiring the PCN to issue its own membership identification). A beneficial side effect of a reduction in doctor shopping and unnecessary emergency room services is an increase in the continuity of care available to a client. Another advantage to PCNs is that unlike lock-in programs which identify clients after they may have incurred thousands of dollars of unnecessary care, PCNs can be used to take care of all clients including potential abusers. PCNs, therefore, catch abuse before it becomes an expensive habit.

3. PCNs guarantee clients a point of entry into the health care. Unlike fee-for-service where clients often find difficulties locating an office based physician who will treat them, PCNs guarantee that access and service for as long as the client accepts the conditions of PCN membership.

4. PCNs are more flexible and more easily established than traditional HMOs. PCNs can be set up as easily and effectively in the inner city as in sparsely populated areas. PCNs potentially offer greater opportunity to achieve a cost effective mode of practice than IPAs because PCNs tend to be more selective in their acceptance of participating physicians. The smaller group allows for a higher acceptance of the PCNs' goals, protocols, and standards of practice than a broadly based and diverse IPA. PCNs can also be less expensive to develop than prepaid group practices because PCNs do not require new institutions or large alterations in existing relationships that physicians have with hospitals and other providers.

   PCN flexibility is also a function of the enormous diversity that can occur between organizations that qualify as PCNs. Designation of primary care physicians can be limited only to general practioners and family medicine physicians or extended to include any physician willing to assume that role. Further, primary care physicians can be restricted only to solo practices and/or groups (either family practice groups or multispecialty groups or both). Specialists may have separate contracts with the PCN or may be selected solely at the primary care physician's discretion. Self referrals may be handled in a number of ways: they can be made the enrollees' complete financial responsibility, paid after the fact and followed by enrollee education on how to use the PCN, or result in forcing an enrollee out of the PCN. Similarly, marketing techniques, utilization controls, quality assurance mechanisms and reimbursement can vary significantly. Despite the variety, the common characteristics of increased control and management of the primary care physician (vis a vis fee-for-service) make all of these organizations PCNs.

B. Disadvantages of PCNs

PCNs, however, are not unmitigated blessings. The advantages of PCNs described above can be counterbalanced to some degree by the following possible disadvantages associated with this approach:

1. PCNs may encourage a reduction in the quality of care provided. There are at least three aspects to this incentive, all of them based upon specific assumptions about the structure of the PCN. Even if the designation of primary care physician is limited to any general practice physician, family medicine physician, internist, obstetrician, gynecologist, or pediatrician, there may be a strong qualitative difference between the non-board certified practioners and the board certified members. The difference may be pronounced and the PCN may be locking its enrollees into the care of some marginal physicians (Although some may argue that board certification is an insufficient proxy for quality). This places a burden on the PCN in terms of quality control and defining how frequently and under what conditions enrollees may change primary care physicians. Second, many primary care physicians do not have the necessary training to deal adequately with a range of medical problems and procedures. However, by structuring a program which greatly increases the primary care physician's control over the patient and financial incentives to minimize specialty referrals, clients may not receive needed services and be blocked from access to additional consultations concerning their problems. Third, even if the physician is competent to make all the necessary medical decisions, the PCN may encourage – depending upon how the capitation arrangements are designed – the primary care physician to refrain from providing needed care. For example, if the PCN capitates the primary care physician for both primary care and all specialist services, the PCN maximizes his income by not providing care and not making referrals. Again this indicates the importance of strong quality control mechanisms under a totally capitated model. (Although, it is not clear whether quality implications of providing too few services under a capitated system are worse than providing too many services under a fee-for-service system.) Alternatively, partial risk-sharing policies can be designed that provide some incentives to carefully monitor the appropriateness of care and avoid financial incentives to deny needed care.

2. Primary care physicians may be unable or unwilling to monitor or supervise specialists. Primary care physicians have by training and practice played a subserviant role to specialists. Primary care physicians traditionally have had lower incomes and less prestige within the profession. The success of PCNs, rests however, with the ability of the primary care physicians to monitor and, if need be to challenge the authority of specialists. It is a role with which many physicians will be unfamiliar and it is not one to which many will easily adjust. As will be discussed in the following section, a principle reason for the demise of United Healthcare, one of the largest and best known PCNs, was that it assumed that primary care physicians would automatically exert much greater control over specialists than they actually did. Although this is not an insurmountable problem, it must be addressed. All physicians participating in the PCN must understand the ground rules from the outset. The primary care physicians must receive considerable support in terms of baseline information, advice from peers, and guidelines and back up from the PCN central office.

3. If the primary care physician receives a capitation payment for primary care only and is not held at risk for all other care, then the PCN has a strong incentive to be less efficient and more costly than fee-for-service. Under this system, the primary care physician maximizes his income by not providing services or by passing on the responsibility for care of as many cases as he can to a specialist. No provision of care would open the physician up to charges of malpractice. The safest route he can take and still maximize his revenues is to maximize his referrals. Thus the primary care physician may render fewer services than he did under fee-for-service, receive a roughly comparable income from the PCN enrollees through the capitation payment, and make more referrals at higher total aggregate cost of care than under fee-for-service.[9] This tendency could be checked if the quality control program is effective, if a primary care physicians capitation rate reflects the volume of services provided during a previous period and if he is financially at risk for referrals.

4. PCNs may foster adverse selection. There are two types of adverse selection which may take place. One would favor the individual physician. The other has the potential to work against him. If enrollees have the option of joining a PCN or remaining with the fee-for-service approach, the primary care physician could encourage the healthiest of his fee-for-service clients to enroll in the PCN. He could discourage his most costly patients from enrolling in the PCN and to continue to be paid on a fee-for-service basis for their services. At the same time he could enroll individuals with a low likelihood of using his services and receive a capitation rate or case management fee for them.[10]

   The second example of adverse selection pertains to a situation in which all Medicaid eligibles are required to select a primary care physician. If there is any systematic selection bias among clients who have not used any medical services or those who are very sick, then some primary care physicians may realize large losses or gains that are unrelated to their ability to manage their practices.

5. The administrative and information systems a state employs for its fee-for-service providers may be inappropriate or inadequate for PCNs. Depending upon the specific characteristics of PCN, a state may be forced to design a specific system for PCNs. The Massachusetts case management experiment, for example, was a demonstration project which did not lock patients into a provider and which generally adhered to fee-for-service reimbursement. Systems problems developed, however, which had not been previously perceived as problems. The state was unable to accurately and reliably trace out-of-plan use on the part of PCN clients (indeed the two hospitals participating in the project were unable to track PCN patients within their own institutions). The state encountered a number of barriers determining what savings had been achieved using PCN rather than fee-for-service even though their contract required that the state share those savings with the PCN participants. When PCNs include lock ins and capitated arrangements, the difficulties encountered can be compounded. The fee-for-service invoice disappears. Monitoring efforts need to focus upon the possible under provision of services and not on the excessive utilization that agencies normally monitor fee-for-service providers for. Enrollment, disenrollment and grievances become important issues which again are not routine fee-for-service problems. All of these factors require that states carefully consider the ramifications of a PCN and attempt to design systems which anticipate PCN behavior.

III. EXAMPLES OF PRIMARY CARE NETWORKS

In order to highlight the range of possible PCN configurations and to provide more detailed information on the actual operation of PCNs, this section presents a discussion of the organization and operation of five existing PCNs: The Health Maintenance Program of the Wisconsin Physician Service, United Healthcare of Safeco, Group Health Plan of Northeast Ohio, Multicare of Multnomah County, Oregon, and the Massachusetts Case Management demonstration project. It also includes a review of three proposed PCNs: the Santa Barbara Health Initiative, Michigan Primary Sponsor Plan and the Physician Based Group Insurance of Baldwin County, Georgia. Again, while diversity may be the hallmark of the PCN, attention should be focused on the relative common role and responsibility of the primary care physician in each of these organizations.

A. Health Maintenance Program of the Wisconsin Physicians Service[11]

Health Maintenance Program (HMP) of the Wisconsin Physicians Service was formed in 1970 to serve 219 people in a rural setting of Wild Rose, Wisconsin. "It is," as one observer has noted, "a unique experiment in formal referral and in direct capitation of primary care within an open panel framework." In addition to being sponsored by one of Wisconsin's two Blue Shield agencies, HMP is one the oldest PCNs in the country and has served as a model for Safeco's United Healthcare and other recent PCN efforts. HMP currently has 182,000 enrollees served by approximately 1900 doctors in 62 of Wisconsin's 74 counties. While HMP does not have a contract to provide services to indigent clients on public programs, public employees are its largest source of enrollees. State employees alone account for 70,000 of HMP's members.

HMP offers a very comprehensive benefit package which includes: inpatient hospitalization, in- and out-patient surgery, office medical care, maternal services, infant and child care, laboratory tests, prescription drugs, limited psychiatric visits and limited preventive vision and dental services. HMPs benefits are more generous than Blue Shield's most comprehensive fee-for-service contract. In fact, HMP is offered by Blue Shield as an alternative to that contract. Capitation for primary care services is one reason that HMP is able to compete so well with other plans offered by its parent organization. With fee-for-service contracts, the cost of processing low cost claims was estimated by HMP to be at least half of the total cost of the benefit. Under capitation arrangements, the

costs to the carrier and the physician for processing low cost items are eliminated. Coverage of low cost benefits, therefore, becomes financially feasible.*

Individuals who choose to join HMP must select a primary care physician. Individual members of a family, however, may select different physicians. For those HMP contracts requiring that a subscriber be locked in, the primary care physician's written approval is required for all non-emergency care. If a patient receives a non-approved service, HMP will not pay for the service. Further, if continued self-referral persists, the patient may be forced out of the HMP program and assigned the lower coverage, traditional Blue Shield policy.

The lock in does not prevent the patient from selecting a specialist as long as that selection is done in concert with the primary care physician. According to the Chief Medical Advisor to HMP:

> "The primary care physician's responsibility is to determine with the participant patient whether a referral service is indicated. The participant patient shall have free choice as to which specialist will be seen. The primary care physician usually guides the referral....However, to avoid antagonism in the medical community, it has worked out well for the primary physician and the patient to agree on the specialist to be consulted. Often patients already have known about other specialists in the community and are free to see them and continue a previous relationship."[12]

If a member disagrees with how his primary care physician treats referrals or is dissatisfied in any way with his primary care physician, he can change his physician by submitting a change of physician card and waiting a minimum of 45 days. It should be noted that the stringency of the lock in and the penalties for violating it vary with different contracts.

The primary care physician can be any physician who wishes to accept that designation. Generally, the primary care physician receives a monthly capitation fee for each HMP subscriber. The capitation rate is based upon the physician's previous years' experience and is adjusted every four months during the current fiscal year. This obligates the physician to directly provide each subscriber with a range of services and to assume the case management function. Services not covered by the capitation fee and specialists are paid on a "usual, customary and reasonable" charge basis.

---

*If this cost benefit estimate for fee-for-service broadly reflects the experience of third parties, and there are indications that it does, then PCNs offer states the means for substantially increasing their low Medicaid fees to office based physicians without increasing their net costs for processing and reimbursing physician services.

The net payment the physician receives for case management is the difference between his "actual costs" (as determined by what his revenues would have been had he used his usual, customary and reasonable charges) and the capitation rate. If actual costs are greater than the capitation rate, the physician receives the capitation plus no less than 88 percent of the difference between the actual costs and the capitation payments. If costs are less than the capitation rate, the physician can keep between 96 to 100 percent of the capitation payments.

The capitation fee is embedded in what HMP refers to as a health maintenance account. The accounts are constructed around providers with more than 500 subscribers (primarily clinics) and those with less than 500 (pooled groups of non-affiliated physician groups and solo practices). HMP receives premium payments from each subscriber in each account, subtracts HMP administrative costs, costs for out-of-plan emergencies and reinsurance for catastrophic episodes. The remaining approximately 80 percent of the premium is placed in the health service fund. This must cover the capitation fee and all other primary care, specialty, hospital, drug and ancillary services covered under the contract.

Actual payments to primary care physicians are subject to a hold back which is settled once the fiscal year ends. If there is a deficit in a physician's health service fund, the physician is liable for up to 12 percent of the loss. Under no circumstances, however, will the physician receive less than 88 percent of the total charges he would have received from HMP enrollees had he billed them on a fee-for-service basis. If there is a surplus in the health service fund, the physician will receive 12 percent of that surplus. The physician, however, will not receive more than 100 percent of the charges he has recorded for HMP enrollees.

Thus, the primary care physician capitation fee is subjected to two year end adjustments: one is a volume adjustment which corrects for the actual services provided by the physician, the other is risk sharing adjustment. Both adjustments minimize the potential losses incurred by a physician to no more than 12 percent of his charges. Since physicians rarely receive 100 percent of their charges (i.e., actual receipts are reduced by bad debts and by intermediaries which may refuse to reimburse 100 percent of the charge) the potential HMP "loss" would not represent a 12 percent reduction of what the physician would have received in the fee-for-service market.

During the mid 1970's HMP experienced some financial difficulties and also applied a hold back to specialists*. That has since been rescinded. Specialists are now paid 94 percent of their usual customary and reasonable charges.

Physicians, therefore, are not subject to enormous financial risks. In part this reflects the position of the Wisconsin Physician Service as an intermediary which must deal with the entire physician community either on a prepaid or fee-for-service basis. It also contributes to the acceptability of HMP to physicians, particularly the County Medical Societies. In Dane County, for example, the Medical Society votes on whether or not to approve the HMP contract. Without that approval, HMP would have a much more difficult time marketing the plan to physicians. After nearly a decade of experience, however, it is unlikely that medical society disapproval would shut down HMP.

In addition to its organizational configuration and official physician support, a factor which has contributed to HMP success has been its careful selection of counties within which it is marketed. The ease with which a patient can change primary care physicians, the ability of any physician to designate himself as a primary care physician, and the limited risks assumed by the primary care physician can make the constraints on referrals and self referrals very weak. HMP has countered this possibility by marketing primarily in rural counties.

As was explained in an unpublished report on HMP:

> ...Self referrals have not been a significant problem, probably because most of the HMP counties have low-physician-patient ratios, small numbers of local specialists, and prevailing habits among patients of seeking help only through family physicians.
>
> The only real test of the lock-ins is occurring in Dane County (Madison), where patients find it easy to take their problems directly to specialists. Strict enforcement of a lock-in threatens to entail massive disruption of established help seeking patterns, disruptions that both patients and physicians would find intolerable.[13]

But the Dane County problem has been averted partly because Madison has an unusual local delivery system consisting of a number of very large multispecialty groups in excess of 50 physicians each. Indeed, seven groups in Madison care for 65 percent of the 80,000 HMP clients in the area. These groups in turn have been very suitable for the HMP arrangement. In-house specialists, peer pressure, and HMP representatives within the

*See page 3 for a description of "hold backs."

groups have all been factors which have helped control self-referrals and made HMP a competitive force in Madison.

B. Safeco's United Health Care

United Health Care (UHC) of Safeco is perhaps the best known PCN in the country. It has assumed several forms from its inception in 1971 to its planned demise in June, 1982. At its peak, it had enrolled 40,000 members from private and government employee groups in Washington, California and Utah. According to Stephen Moore, et al, in 1980 UHC had "three innovative features":

> The first is organization of the entire health care delivery system through the primary care physician. The plan contracts with family physicians, internists and pediatricians who are private practioners. They become the "general managers" for referral specialty care, emergency room use and hospitalization. Self-referral by the patient is not paid for by the plan unless it has been approved by the designated primary care physician....
>
> The second is that the primary care physician becomes the financial manager for his patients in the cost of care. Premium dollars are paid into the plan by employers or employees...About 80 percent of these premium payments are placed into the accounts of participating primary care physicians. The remaining is the current cost for administering, marketing and reinsuring the plan....The physician account is divided into two parts. The first part of the account covers the services of the primary care physician. If there are fewer than 200 members in the physician's panel, then reimbursement for office and hospital visits is based on a fee-for-service system at a reimbursement rate of 95 percent of the charges. If there are 200 or more members in the panel, the physician is paid a fixed monthly amount....The (second part of the) account is used to pay all services not provided by the participating physician.
>
> The third innovative feature...is an incentive system to encourage the participating primary care physician to take seriously his new role as coordinator and financial manager....(by requiring the) physician to share in any deficit or surplus in his account at the end of the year. The physician must share 50 percent of the deficit or surplus with the plan up to a maximum of 10 percent of his non fee-for-service office charges. Under capitation...the surplus is limited to 50 percent of his capitation revenue and that of the deficit is limited to five percent of the capitation revenue.[14]

In fact, it was UHC's failure to fully implement these three innovative features which led to its collapse. In order to place UHC in perspective, a number of issues must be examined. It is necessary to distinguish UHC from HMP of Wisconsin, review the effectiveness program UHC had in effect in 1980, examine why UHC failed, and explore why the changes adopted several month's prior to Safeco's decision to close down UHC probably would have saved UHC.

In contrast to the Wisconsin HMP plan, UHC was targeted solely at primary care physicians in the community. There was a decided attempt by UHC to affix the responsibility onto each individual primary care physician. Thus, each physician had his own individual account rather than the pooled arrangement of HMPs Health Maintenance account. The risks for exceeding on account or accruing savings were placed firmly in the hands of each UHC primary care physician. The UHC program, however, had a certain amount of ambivalence about the extent and severity of the risk. Thus, while many of Wisconsin's HMP primary care physicians were capitated, very few UHC physicians qualified for capitation, that is, very few had UHC panels in excess of 200 members. In 1978-1979, the average number of UHC patients per participating physician was 25. In fact, 97 percent of the primary care physicians in UHC were reimbursed on a fee-for-service basis. Finally, while UHC attempted to place a greater burden on the primary care physician than did HMP, it treated specialists' fee schedules more generously than HMP. UHC reimbursed specialists at 100 percent of their charges.

A review of UHC's experience by a panel of University of Washington investigators has shown that all those involved with the plan – the members, primary care physicians and specialists – looked very favorably upon the plan. Preliminary results from a study comparing Washington State employees in UHC suggest that case management may reduce costs although there is some indication that adverse selection took place on the part of those enrolling in UHC (i.e., sicker individuals enrolled in UHC)[15]. Nonetheless, in 1980 UHC experienced so large a deficit that Safeco attempted first to sell the plan and then, failing that, Safeco decided in 1981 to close UHC down. The question is: what went wrong?

The answer is not a simple one, although it appears that one of the major contributing factors to UHC's troubles was the failure of primary care physicians to control specialists to the extent anticipated. UHC's policy of reimbursing specialists at 100 percent of their rate made UHC one of the most lucrative carriers in the area, and offered specialists a powerful inducement to provided a full range of services to UHC members.

There were a number of reasons why the primary care physicians proved to be ineffective supervisors of these specialists. A major problem was their reluctance to confront specialists. They were willing to approve specialists services after the fact, even though the primary care physician had not granted prior approval. In addition, the

"at risk" incentives established for the primary care physician proved to be relatively inconsequential and ineffective. Physicians had too few UHC patients and too little to lose or gain to force any change in behavior. In 1979, two thirds of the 470 participating primary care physicians in Seattle, Spokane and Bellingham had less then 30 UHC members and UHC contributed to only 5 percent of the physicians' income. Approximately half of the UHC physicians received an average bonus of $413 for a surplus in their accounts. The most received by any single doctor was $5,001. On the other hand, the 50 percent of the physicians experiencing deficits in their accounts and paid an average penalty of $169. The largest physician payback was $1,833.[16] Thus while deficits were accruing in UHC because of excessive costs incurred by specialists, the primary care physicians were actually bearing very little of the financial risk or responsibility.

Ross Bond, former Chairman of the Board of United Healthcare and President of Safeco, noted three additional problems. First, the national recognition and debate surrounding UHC prompted a constant stream of speaking requests by agencies and organizations throughout the country. As a result, chief administrative UHC personnel spent too much time traveling and talking about UHC and not enough attention at home. Second, UHC management was not "communicating properly" with the primary care physicians. The physicians did not receive the assistance and information they needed on what was happening within UHC and UHC failed to find out from the physicians how they were adjusting to or changing with UHC. Finally, although UHC had accumulated an enormous amount of data, it had enormous difficulty accessing that data on Safeco's computers. UHC was forced to process the data themselves. It was then that they discovered that they had lost control of the specialists and that they had too many primary care physicians. (All those who claimed to be primary care physicians did not behave the way UHC had expected). They also learned that the benefit package had been too liberal, a fact which seemed to lead to high utilization rate for mental health and alcoholism inpatient services.[17]

By April 1980, the effects of UHC's problems became apparent. At that point, the deficits had reached $1 million. According to Robert Gregory, the former director of UHC, it then took four to five months to determine what had to be done in order to bring the plan back into financial solvency. These measures included:

1. Removal of primary care physicians unwilling or unable to operate according to UHC guidelines. High cost primary care physicians were removed from UHC.

2. A formal referral mechanism was designed whereby specialists were required to receive a referral slip from the primary care physician before services were rendered.

3. Specialists' participation in UHC was limited to those physicians who were willing to accept UHC's referral system and the imposition of a number of utilization controls concerning hospital admissions and length of stay criteria. (Control over the specialists' use of hospitals was essential since they accounted for 70 percent of the hospital days.) A fee schedule was imposed which was set at approximately the 70th percentile of submitted invoices.

4. Benefits were changed. Deductibles and copayments were used to tighten up the members consumption of services.[18]

UHC was not able to implement all of these changes immediately. They began in October 1980 but some alterations required changes in existing contracts. Therefore, UHC had to wait for contracts to expire and renegotiate new agreements with the desired modifications.

The effects of the new policies appeared to take hold quickly. Hospital days per 1,000 enrollees dropped from a high 500 prior to changes to 300 afterwards. The total costs of hospital care in July and August 1981 were less the costs experienced during the same months in 1979. Unfortunately, Safeco, the parent company of UHC, was unwilling to absorb any further losses incurred while UHC readjusted its plan. UHC will close down when its last contract runs out in the Fall of 1982. However, Roswell Bond, former Chairman of the Board of United Health Care, has established Healthnet Management Services, Inc., and is marketing the UHC model to self-insured employees.

C. Group Health Plan of Northeast Ohio

In terms of our discussion, Group Health Plan (GHP) of Northeast Ohio serves as a bridge between the private and public sectors. It is a very successful model of an integrated health care plan. GHP contracts with only primary care physicians. It has 28 individual and medical practice groups representing 125 physicians working out of 38 sites in six counties within the Cleveland metropolitan region. Since the plan became operational in 1975 it has grown at an annual rate of 18 percent per. Currently it has 24,000 members, of which approximately 6,000 are Medicaid recipients, 3,000 are funded with the Bureau of Community Health Service's 330 money, and 15,000 are non-indigent members. The non-indigent members represent a number of group contracts with private firms (e.g., General Motors and the Meatcutters Union) and government agencies (e.g., State of Ohio employees, Cuyahoga County employees and the Cleveland Board of Education). The integrated nature of the enrolled population means that a client could

pass through a series of program eligibility (i.e., Medicaid, then "330" and then private employment) without having to change his "insurance carrier" or his physician.

GHP began as one of the original eleven networks funded in 1971 under the 330 effort to provide care to the poor. With federal advocacy and growth of the HMO movement and with belief that GHP should not be restricted to the poor, GHP successfully diversified its marketing efforts. GHP's origins are important because unlike HMP it does not have to create policies which are acceptable to the county medical society. Rather it has had to create a program acceptable to its member physicians and subscribers. This has given the organization considerable freedom. For example, it has terminated three medical groups for failure to meet contractural obligations. It also has embarked on a rather innovative path of making the primary care physician directly responsible for contracting with and paying specialists required by the primary care physician's patients. Thus GHP has avoided some of the specialist problems encountered by Wisconsin's HMP and United Healthcare. This also does not mean it has eliminated all the problems. A number of issues need constant attention: the adequacy and appropriateness of specialty referrals, hospital cost and utilization, and quality of care. GHP monitors cost and utilization data closely, provides physicians with the necessary information needed to evaluate their practices, and has frequent meetings with groups of participating physicians to review medical records. The chief medical director plays a critical role. He not only directs and organizes the computer reports and peer review meetings but because he knows all of the individual physicians, he can effectively discuss problems with them and, when need be, apply the appropriate pressure to force compliance with GHP standards.

The rapid and accurate retrieval of relevant data is an essential component of GHP. It has greatly contributed to GHP's capacity to monitor and administer their program. The lack of an adequate data system can, as in the case of Safeco's UHC, cripple a PCN. According to Max Davis, President of GHP, their information system consists of:

> "CRTs that are on line with a large computer owned and operated by Medical Data Systems of Cleveland, Ohio. This provides instantaneous entry and recall of all information. At the time of the visit, the physician fills out a short encounter form, providing information as to diagnosis, medication prescribed, lab and x-rays ordered, referrals ordered and the relative value of the services provided. When this data is entered into the system, it enables Group Health Plan to monitor the quantity and some aspects of the quality of the health care provided.[19]

GHP's contract with its primary care physicians is an interesting melding of incentives and constraints. In 1981 physicians received $11.50 per enrollee per month for all non-Medicare enrollees. This obligated the physician to directly provide or pay for all outpatient physician services, drugs and medicine administered in the physician's office, outpatient lab and x-rays, all surgical operations and procedures, specialists care, limited mental health services (20 visits per patient per year), limited physical therapy (10 treatments per year) and home health care.[20]

The physician's risks were limited by three mechanisms:

1. A two tiered approach to catastrophic losses was established, protecting medical practice groups against large costs incurred by any individual GHP member. The level of protection decreases as the number of GHP members enrolled increases. Thus if enrollment is between 1 and 400, GHP will pay 80 percent of all costs in excess of $600 per member. If enrollment is greater than 2,500 individuals, GHP re-insurance begins at $4,000 per member. Regardless of the practice, once costs per individual member exceed $10,000, GHP will pay 100 percent of the costs. Two levels of protection insure that the physician will not lose financial interest in a patient once that patient incurs costs which qualify for the first tier of insurance – the 80 percent GHP coverage – but holds the physician truly harmless for unmitigated catastrophies.

2. While GHP pays for hospitalization, medical groups are rewarded for controlling hospital use and are at risk for excessive utilization. At the end of a fiscal year, projected hospital expenditures per member month are compared with the actual per member month experience within each group. If actual costs are less than the projection, the medical group receives half of the difference. If costs exceed the projection, the medical group is responsible for those additional costs up to an amount not exceeding 5 percent of the capitation paid to the medical group. This risk arrangement is similar to the one that was used by United Health Care. It is a post hoc financial device whose effectiveness depends upon the reasonableness of the hospital day projections and the awareness of the physicians group that they are exceeding projected rates. It did not prove to be much of a deterent for United Health Care.

3. If during a 12 month period the cost for medical or surgical specialty services exceed more than 150 percent of the medical groups capitation fee, GHP will advance the group an interest free loan to cover those excess costs. The conditions of the loan, however, require a relatively fast repayment to GHP. The loan arrangement, therefore, acts to reduce the risks incurred by permitting a group to effectively carry forward their losses and offset them against future profits.[21]

The net effect of these constraints on physicians has been very favorable. The capitation rate compared very favorably to revenues the physicians would have received if they had changed their usual customary and reasonable charges to GHP patients and experienced a 100 percent collection rate. The average medical group "charges" would have produced approximately 92 percent of the capitation rate. The cost for specialist services accounted for 28 percent of all physician services.

1. GHP and Medicaid

The GHP Medicaid project grew out of a 1978 pilot project. Enrollment has grown steadily to a current AFDC membership of 6,000. With the exception of nursing home care and a few expensive esoteric services, the GHP Medicaid benefit package includes preventive care plus all the services available to non-GHP Medicaid recipients. GHP received $50.50 per enrollee (approximately 95 percent of the average adjusted per capita cost of comparable fee for service clients).* GHP also assumes full risk. Any losses or savings are "wholly retained by GHP". In an interesting federal interpretation of the Privacy Act, GHP has been treated as an administrative extention of the state central office and given the names and addresses of Medicaid clients in the GHP catchment areas. (This has been a particularly sticky problem for other Medicaid HMO contracts. States are not allowed to share eligibility information with HMOs, i.e. inform HMOs who the Medicaid recipients are in their area. In many cases, this forces expensive door to door marketing efforts in areas with a large percentage of Medicaid recipients.)

The difficulties that have arisen in the contract between GHP and the Ohio Medicaid program have involved administrative problems with the eligibility and enrollment process. For example, because of the lag between when a service is provided and

*The primary care physician receives approximately twenty-eight percent of the premium and the remainder covers hospitalization and other services the primary care physician is not responsible for.

when provider submits a bill, GHP would often be billed for services provided prior to but submitted to the state after GHP enrollment of a client. If a Medicaid GHP client failed to keep an appointment with the welfare office for the mandatory recertification of his Medicaid eligibility, he would be found ineligible. If he showed up the next day and was recertified, the client would not be reinstated in GHP but issued a standard fee-for-service Medicaid card and purged from GHP's rolls by the state. GHP would then have to re-enroll that client. Another problem seems to have arisen from the ability of a GHP Medicaid client to walk into a welfare office, claim that he did not receive his Medicaid card, and have the welfare worker issue a fee-for-service Medicaid card. When this occurs the state effectively pays twice for the client. Once in terms of GHP's capitation fee, and the second time in terms of the out-of-plan services that GHP would not recognize but that were provided by participating fee-for-service Medicaid providers.

Another area of concern for GHP has been the loss of the Medicaid hospital discount. When states contract out with HMOs, the HMOs frequently must pay hospital charges or negotiate rates. If that happens and if the net result is more expensive than what Medicaid's cost-based reimbursement would have paid, then both the HMO and the state lose. One method for solving this problem is to permit the HMO to purchase hospital services through the state. Another would be for the state to require that all hospitals charge all Medicaid clients the same rate regardless of the carrier.

These problems aside, the GHP Medicaid contract has been very successful. Both parties are pleased and both are considering expanding GHP's participation. At present GHP is negotiating the possible take over of an entire nearby county. In an approach similar to the Redwoods Plan of California, all clients would automatically be enrolled in GHP and would have to abide by GHP's program requirements.

D. Multicare of Multnomah County, Oregon

Without question, Multnomah County, Oregon has been one of the most innovative counties in the country. Among other things, it has integrated "Multicare," a public PCN, with "Project Health," a program which pools public funds and brokers private health care plans for a medically indigent population. In order to understand Multicare's function, it is necessary to understand what Project Health is and how Multicare relates to it.

Project Health was developed in 1973 by the county after the state legislature transferred control of the county hospital to the University of Oregon. This freed up $4.2 million which the county could use to provide care to the medically indigent. The means for doing this, however, are slightly unorthodox. First, the county pools its health resources from all available sources (county funds, Public Health Service 330 grants, client payments and provider refunds). Second, the county acts as a broker for its client by negotiating prepayment contracts with four prepaid health plans and, until recently, by offering an episodic care plan which paid for office visits to individual physicians and had limited hospital coverage. All prepaid plans have a minimum benefit package which they must offer. The plans, however, differ slightly with respect to the extent of coverage, whether or not copayments are charged for specific services, and the dollar amount clients must contribute to their capitation rate (a sliding payment determined by the size of the family, its income, and the cost of the plan chosen). Project Health provides services to the 12.5 percent of the county's residents considered medically indigent. During FY 1979-80, a total of 16,000 individuals were served by Project Health, 4,748 individuals were enrolled prepaid plans, 8,507 received episodic care and 11,476 individuals received special services such as dental care, rape evidentiary exams, and ambulance services. The total cost in 1979-80 was $9,439,610. Proponents of Project Health argue that it offers the best mix of policy goals available. Specifically, it is claimed that Project Health allows the consumer freedom to choose among participating providers; makes consumers more involved and sensitive to costs by requiring copayments and premiums and stimulates competition among health providers. Project Health does more than encourage cost containment through prepayment and integrate fragmented public programs by pooling resources. It also moves closer to the voucher method of providing health care coverage; that is, it offers enrollment in competing health plans to eligible individuals and assists them in making intelligent choices. Similar to an employer, Project Health pays a portion of the premium based on the client's income, family size, and plan selected.

This limited voucher approach, however, has over time led to a situation of adverse selection. This has meant that the sickest, most expensive clients joined the health plans with the broadest selection of community providers involved. This permitted sick patients with established physician relationships to continue to see their own physicians. As a result, the agreed upon capitation rates were insufficient to cover costs. This in turn forced the health plan with a flexible IPA arrangement out of the program. It compelled another health plan to substantially increase its premium and close enrollment to Project

Health clients for an extended period of time. The adverse selection has been the result of three factors. First, the Project Health population tends to be less healthy than the general population. Second, the least healthy from that population have tended to join the health plans with the open physician panel. Finally, since Project Health required the poor to share in the cost of the premiums and some health plans required co-payments, many individuals disenrolled who had their health problems cared for and who did not expect to be ill in the near future. Those with chronic conditions who expected to be sick in the near future continued to pay the premiums.[22]

Project Health has responded to this problem by screening applicants through the use of a health status appraisal questionnaire and placing high risk clients into the county's own case management health system called Multicare. Multicare is a joint venture between the Multnomah County operated clinics (which served 48,000 indigent patients in 1980) and private providers. A broad range of services is available but all preventive and primary care take place in the county clinics. A case manager is responsible for each patient. He is responsible for assessing the clients short and long term needs, developing and managing a health care plan, authorizing all necessary referrals and approving all referral billings after the care is provided. Referrals consist of specialty service not available in the clinics, as well as hospitalization, drugs and emergency services.

Referral providers will be limited to "the most compatible, high quality, cost effective providers in the community." Project Health has defined those characteristics in the following way:

1. Compatible providers are those who are prepared to cooperate with the Multicare referral system and who are willing to commit themselves to the program's cost-containment objectives.

2. High-quality providers are licensed or certified providers who are willing to allow review of their practice through recognized quality assurance measures.

3. Cost-effective providers are those who are prepared to use less costly, appropriate procedures to serve patients, for example:

    a) Outpatient surgery, when appropriate.

    b) Prescription of generic drugs, when appropriate.

    c) Ordering of outpatient tests, when appropriate.

4. Limitation to such providers will be achieved by:

a) Working closely with community providers in order to achieve objectives of the Multicare program, the quality review provisions and the cost containing payment arrangements.

b) Selection of participating referral providers based upon the Project Health experience.

c) Establishment of referral provider panels, including one for physicians and one for hospitals to review problems and practice and to develop standards.[23]

The system is an effective public PCN with one difference. Once a high risk client's health care needs are met, he will be allowed to choose whether he wishes to remain in the program or join one of the other HMOs participating in Project Health. During this first year of operation, Project Health will collect and analyze utilization data which may allow them to establish a capitated rate for Multicare and negotiate rates with prepaid plans. Negotiations are currently underway with the State of Oregon to capitate a rate for the AFDC population served by Multicare.

Adverse selection was threatening the financial solvency of Project Health's competitive system. By screening out the worst cases into a public PCN*, Project Health may well preserve the participation of the private health plans in the program. But the experience must serve as a cautionary note to all those who endorse vouchers, ignore adverse selection and claim that competition can easily be introduced into the medical market place.

The Multicare approach might have particular appeal for a state's Medicaid program because there is some indication that a disproportionate amount of funds are being consumed by a very small portion of the Medicaid eligible population. For example, in New York City in fiscal 1980, 1,322,000 people received Medicaid services. Total average costs per recipient was $1,512 but averages are misleading. Half of the recipients received $275 or less services. The "most typical" recipient (the mode in the distribution) received $64 in services.[24] This distribution in expenditures is made more striking by the fact that these costs only represent individuals who actually received care during the year and not those who were eligible but did not use any services.

In another relevant study, Maryland examined the cost and utilization experience of Medicaid eligibles in the City of Baltimore. In fiscal 1980, one third of the individuals in

*This is the opposite of cream skimming. In fact, this approach might be termed "skim milking."

the sample of 776 eligibles did not receive any care. Eight percent were enrolled in HMOs and there was no utilization data for them. The remaining recipients of services were divided into three groups: those who received care only from physician offices, from institutions (either outpatient departments or emergency rooms) or from both physician offices and institutions. As can be seen in Table 2, those who received care from

TABLE 2

Source of Care	Percent of Recipients	Average Number of Ambulatory Visits	Number of Hospital Days per 1000
Physician Offices	17	2.9	350
Institutions	58	4.4	2,200
Physicians Offices and Institutions	24	7.5	1,200

physician offices had the lowest number of ambulatory visits and hospital days. Those using institutions only had 1.5 times the utilization rate for ambulatory visits as those seeing physicians only and more than six times the hospitalization rate. Those using both physicians and institutions had the highest number of ambulatory visits but lower hospitalization rate than those relying solely on institutions. Of course these differences could reflect differences in the recipients seeking care from the different sources. Preliminary assessments of the effect of adjusting utilization rates by category of program (e.g. AFDC) has not revealed any change in the magnitude of the differences in the rates of hospitalization by sources of care. The study did find that the cost of supporting a system of ambulatory care in institutions was a very expensive proposition. Total average cost for a physician visit was $14.87 while the total average cost for an outpatient department or emergency room visit was $54.09.[25]

If the New York and Maryland studies are at all representative of experience through the program it can be assumed that very few of the recipients account for a large portion of those costs, that those that rely upon institutions for ambulatory care are much more expensive to care for than those seeking care elsewhere, and that a mechanism for controlling these high cost individuals (A Multicare PCN) might be the most effective means for controlling costs.

E. The Massachusetts Case Management (MCM) Demonstration Project

In 1977, the Massachusetts Department of Public Welfare undertook a study to examine the feasibility of reducing health care costs without reducing the quality of care through a case management system. In 1978 the actual delivery of services in the demonstration project began. Over the following two years six providers (a hospital outpatient department, hospital-licensed health center, community health centers and a group practice), joined and 2,900 AFDC families (10,000 individuals) were enrolled. The AFDC clients represented 1.8 percent of the total Medicaid recipients in the state.[26]

This demonstration project was the most flexible and least constrained PCN of the ones discussed in this paper. The state helped to market the program to recipients and was able to enroll 1,000 to 2,500 individuals per provider. Individuals who enrolled agreed to allow the case management providers to "coordinate their total care and refrain from making arrangements of their own. The coordination of care was intended to both increase quality and reduce inappropriate use of specialists, inpatient care and hospital emergency rooms."[27] Recipients received a $7 a month bonus for joining MCM and accepting a "restricted" Medicaid card. It should be stressed that it was the state's marketing representative who assumed the responsibility for monitoring and sanctioning out of plan use by enrollees. This reduced provider responsibility and, to some extent, provider awareness of the program.

Case management providers agreed to directly deliver primary care and make and carefully review all referrals to specialists and hospitals. Providers benefitted from participating in MCM because they received assistance in setting up a 24 hour telephone call in system, developing more effective record keeping (if needed) and marketing their services. Also if the cost of providing the MCM clients was less than what it would have been had they stayed in the fee-for-service system, then the providers would share those savings. The three providers reimbursed on a fee-for-service non risk basis would receive 40 percent of the savings. Providers who accepted a very limited risk sharing arrangement would receive 50 percent of the savings.

The successful implementation of MCM was hampered by three factors. First, at three of the sites, a restricted Medicaid card did not mean that a client could not receive unapproved care elsewhere. Patients could and did, and those claims were paid for by the state.

Second, providers were either not at risk at all or to such a limited degree that the threat of losing money was essentially absent. Physicians were treated as fee-for-service providers. The lack of risk, in turn, created a certain indifference to the project on the part of some of the physicians. For example, interviews with hospital based and community center participants revealed that they viewed MCM as an administrative arrangement which did not change the way their physicians behaved.

Finally, neither the state nor several of the sites had the data systems necessary to implement and monitor a case management project. Massachusetts does not have a Medicaid Management Information System. Many procedures which could be handled more rapidly and accurately by computers are done by hand. This created a number of problems. For example, MCM clients were informed that if they used out of plan services they would lose their $7 monthly check. At four sites, claims for off-site use were reviewed after they were paid by Medicaid, often three months after the date of service. The match with the referral and telephone and telephone logs at the sites (to confirm whether the referral had been approved) was time consuming. As a consequence, sanctions for recipients who went out of plan were not timely.[28] In fact those sanctions were often not applied. If the state and the sites had a means for quickly identifying and reviewing MCM claims, this problem could have been averted.

In another example, there were problems with processing information about the eligibility status of clients, particularly those who had recently undergone eligibility redetermination (an event that occurs every three months in Massachusetts). As in Ohio, redetermination often resulted in advertantly removing the case from MCM and placing it back in the fee-for-service market. An attempt was made to manually produce a monthly listing of "new enrollees, disenrollees, cumulative enrollment and current enrollment for each site." According to the state, "for a number of reasons it was difficult to generate accurate lists in a timely fashion." In fact, in some of the sites the lists were so infrequent that they did not contribute substantially to tracking clients.

A failure on the part of some of the providers to have integrated records created internal problems. In the hospitals participating in the MCM program, MCM clients were not clearly identified within the hospitals. It was, therefore, not unusual to find MCM clients self referring to specialists within a hospital that also had a MCM primary care physician in one of its outpatient departments.

The weak incentives and the inadequate support systems prevented MCM from being a true test of a case management system. When asked how they might re-organize the project if it were to be done over again, staff within the Massachusetts Department of Public Welfare suggested that the following should be taken into account:

1. It would be more effective to operate case management out of free standing clinics and offices. The use of outpatient departments in tertiary care hospitals creates too many conflicting goals.

2. Both providers and the state should develop the necessary data systems prior to the beginning of the project.

3. Patient education must be an integral part of the program not only in terms of accurately marketing the plan but also in terms of teaching the patient how to use the system correctly (e.g. proper phone use, not using the emergency room for non-emergencies, and so forth).

4. Patients must be locked into one primary care physician and that physician must bear the financial and medical responsibility for managing all of the patient's health care needs.

5. The quality of care must be reviewed and monitored. Computers and nurses can be used to screen questionable cases to be reviewed by physicians. It is important, however, that the state have access to all the clients' medical records.

6. The sites should be accessable to the client. There should be a 24 hour on call system in operation and visiting hours should strive to accommodate the recipient. There should be time allotted for walkins. And, transportation to the sites should be provided, if offices are not conveniently located.

F. Santa Barbara Health Initiative[29]

California has been and continues to be a state which experiments in a large variety of innovative methods for providing health care services. PCNs are being employed by both the private sector (e.g., Take Care and Healthnet) and the public sector (e.g., the

Alviso Health Plan, Monterey County and Santa Barbara). The Santa Barbara Health Initiative (SBHI) distinguishes itself from the other public efforts for the following reasons: it has only one benefit package, it provides nursing home care, all Medicaid eligibles residing in the county are required to join, and recipients are guaranteed six months eligibility regardless of changes in their welfare status.

SBHI is a county run and organized PCN designed to serve Medicaid recipients. In 1980 Santa Barbara had 26,900 Medicaid clients living within the county: 11,600 AFDC, 7,000 SSI, 4,200 Medically Needy, and 4,100 Medically Indigent. The last group was paid through California Medicaid but not eligible for federal matching funds. One third of the clients have Spanish surnames. These recipients incurred $29 million in medical services or $1,080 per eligible per year. Hospitals received 44 percent of those expenditures, nursing homes 20 percent, physicians 20 percent, pharmaceuticals 6 percent, dentists 4.5 percent and the remaining providers 5.5 percent. Medicaid costs have increased at an annual rate of 15 percent over the past several years.

Santa Barbara also has an excess of physicians and hospitals. In 1973 there were 216 physicians per 100,000; most of these doctors were located in Santa Barbara City and the wealthy southern portions of the county. There are seven hospitals in the county. Occupancy rates vary between 44-70 percent. In 1979, three hospitals operated at a loss.

Medicaid access, however, is limited. Thirty physicians and two community clinics account for more than 70 percent of Medicaid physician expenditures. Thus, despite a surplus of providers, the geographic maldistribution of those providers and physician refusal to deal with the Medicaid program had made access and continuity of care an issue. The institutional bias in the Medicaid program, rapid rates of increase in costs and limited state and federal budgets have, as in most other counties in the country, made costs an issue.

SBHI intends to deal with these problems through a county operated PCN. SBHI would offer all the benefits (with the exception of dental care) provided by the state Medicaid program. Every client in the county would have to select an "entry physician." The entry physician will render primary care on a capitated basis. The capitation rate will be age, sex and program adjusted. This adjustment is intended to reduce the costs associated with any adverse selection. The entry physician will also receive a case management fee to review and approve all the medical care the client receives. Unapproved

services will not be reimbursed. The entry physician will share in any savings which might accrue to SBHI but is not at risk for any services other than those primary care services he is directly responsible for rendering.

SBHI will receive two prospectively determined budgets from the state. One will cover administrative costs. The other will cover all medical services. The medical services budget will include: a risk pool for catastrophic costs; a capitation fund for entry physicians specialists, hospitalization, pharmacies, and nursing homes (although all but entry physicians, can choose to continue to be paid according to standard Medicaid regulations within the limits of the fund); a hospital block payments fund which pays hospitals 50 percent of their projected costs on a monthly basis (the remainder is paid from the capitation fund according to Medicaid fee for service per diems and ancillary costs); a contractual set aside for all other providers who can choose to be paid according to standard Medicaid regulations within the limits of the amounts budgeted for their services or choose to go at risk; and, a savings fund which will serve as a residual fund, the source of the case management fee and the repository for any savings (or profits) SBHI might realize.

Detailed plans have been made for controlling the quality of care. A physician peer review, pharmacist peer review and consumer grievance committee will be established. Data systems will be integrated to allow for at least three general levels of review.

- Prospective Quality Assurance: health education and disease prevention for Medicaid beneficiaries, case management training of entry providers and their staff, prior authorization for provision of services and payment by entry providers and institutional pre-admission controls.

- Concurrent Review: establishment of quality standards for entry and referral physicians, hospital outpatient departments, pharmacies, and other...services, computerized tracking on a daily basis of volume and mix in all settings for covered services, development of quality assurance screening mechanisms, and establishment of service and,

- Retrospective Review: random computerized audit of all participating entry and referral physicians hospital outpatient departments, other ambulatory services and institutional health services.[29]

SBHI has solved a number of PCN problems encountered by a Medicaid intermediary. The difficulty of marketing the plan to eligibles and overcoming eligibiity procedures such as the redetermination process have been resolved by enrolling all clients in the county and guaranteeing eligibility in blocks of 6 months. The lock-in to the entry physician is

enhanced by his required approval for reimbursement to all other providers and by the clients' lock-in to any given entry physician for a minimum of six months. Since SBHI will be an organization of the county, it will make the county much more than a conduit of funds and provider of care of last resort. It will allow the county to leverage control over the medical care system and allow it to share in any savings.

There are, however, several issues which have not been fully addressed. The organizational structure of SBHI is still being debated. It is not clear whether SBHI will be an enterprise fund within county government, a separate non-profit organization, a special district of the county, or an agency created through California's Joint Powers Act. Each option carries with it different legal and financial implications.

The problem of adverse selection may persist despite the uniform benefits, universal eligibility and age, sex, program adjusted capitation rates. Currently, relatively few doctors care for a large portion of the Medicaid patient population. If SBHI is able to attract a larger number of physicians because of reduced paperwork, faster payment and/or the threat of lost referrals it is quite possible that the former high volume physicians will retain their sickest patients – those with strongly established physician relationships – and lose their less sickly patients to other physicians who are more conveniently located for those clients. There might be also a biased selection of board certified physicians or certain clinics by some clients. The point is that adverse selection may not have been completely solved by SBHI.

The financial arrangement with the entry physician may be insufficient to accomplish the desired goals. The entry physician is not at risk for specialist expenses and does not share in losses if the total plan experiences a loss. In fact, the current arrangement has a very strong incentive for the entry physician to shift as much of his patient care onto specialists since that will increase his income or decrease his work. Further, it is not clear whether a fee for case management and a possibility to share in SBHI's savings provides a sufficient incentive (certainly the generous savings formula in Massachusetts Case Management project should have produced a much larger response on the part of providers). It also is not clear how the case management function will be evaluated and what will happen if such an evaluation proves unfavorable.

Finally, SBHI has to date placed only the entry physician at risk. It has given all other providers the option to continue to be reimbursed in a fee-for-service mode as long

as they do not exceed the amount allocated for their services. What has not be indicated is what happens if the plan experiences serious losses. Who absorbs those losses? How are they distributed across providers? Failure to explicitly set these conditions forth implies an SBHI assumption that there will be no losses; the United Healthcare experience should be a warning that losses at least are possible.

G. The Michigan Physician Primary Sponsor Plan[30]

The Michigan proposal is the most ambitious PCN in the country under consideration. The Michigan Physician Primary Sponsor Plan (PPSP) will have several standard features of a primary care network. Clients will be locked into one physician or sponsor who will provide all of their primary care and approve most of their non-emergency medical care. Primary sponsors will be reimbursed on a fee-for-service basis and will receive a monthly case management fee of $3 for each enrollee. PPSP also has two distinguishing characteristics. First, when it becomes operational in early 1982, it will enroll 323,000 Medicaid eligibles in Wayne County (Detroit) into a state run PCN. Nearly 40 percent of the state's clients will receive care through the PPSP or through established HMOs serving Wayne County Medicaid recipients. The size of the proposal is an indication of the precarious financial condition of the state's Medicaid program as well as the sophistication of that program. Since the 1975 recession, Michigan has been continually exploring and implementing innovative methods for controlling health care costs. After seven years, however, the number of untapped solutions directed at specific providers and the return on those solutions has become much smaller. Increased reductions in expenditures required a change in the health care delivery system and widescale client enrollment. They also required a willingness by the state to accept the experience of more modest demonstration projects and programs, bypass the experimental stage and embark on systemic changes in the way medical services are provided.

Second, MPS is a joint effort of the Michigan Department of Social Services, the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons. Formally, that cooperation was mandated by the state's legislature (Public Act 35 of 1981). The Act required that the Department of Social Services and the professional societies should develop an alternative method for reimbursing physicians. The cooperation also signaled an appreciation of the desperate financial condition of the state and the Medicaid program and the need by both parties to act in good faith to resolve the problem.

The state will require most Medicaid clients in Wayne County to select or be assigned to a primary sponsor participating in PPSP. However, a number of clients will not be allowed to participate in PPSP. Those excluded will include any client residing in a nursing home, enrolled in HMO, eligible for Medicare (the Title XVII/XIX "buy-in" recipients) or eligible for Medicaid under the state's medically needy program. The great majority of the enrollees will thus be categorically needy AFDC recipients.

The state will generate through its Medicaid Management Information System a listing of all clients who have received care within the past six months from a physician who has elected to be a primary sponsor. The state will use the information to assign recipients to a sponsor. The client then will be informed through the mail of the nature of PPSP and the name of the physician acting as his primary sponsor. Participation in the program is mandatory. If the client wishes to receive care he must either accept the primary care physician assigned to him, choose another primary sponsor or join an HMO.

Since the initial assignment of clients will be based on recipient data, eligible clients who did not use services in the past six months will not be assigned a primary sponsor. Those clients will be offered the PPSP and HMO choice when they undergo their periodic redetermination of their eligibility. New clients will be given the option when they are first determined to be eligible for Medicaid by their case worker.

Primary sponsors will be any physician or group of physicians participating in the Medicaid program who elects to assume the role of the primary sponsor, render primary care and operate within a setting that "has control of the recipients' medical chart." For the most part, these sponsors will have practices in general practice, family practice, pediatrics internal medicine or obstetrics/gynecology. However, any physician in any specialty operating out of any ambulatory care setting (e.g. an office, clinic or outpatient department) can join the program as long as they accept the five major conditions of participation. That is, the primary care sponsor must:

1. Provide and/or arrange for all medicaid covered services for his recipients with the exception of vision, dental, long term care, mental health and emergency services.

2. Be available or have appropriate coverage for his Medicaid recipients on a 24-hour basis.

3. Authorize all referrals and must be notified when the client is hospitalized.

4. Submit all invoices for services directly provided by the sponsor within six months of the provision of the care.

5. Accept the standards of care developed jointly by the Department and the Medical and Osteopathic Societies. Statistical screens will be developed for per recipient utilization and costs for lab tests, prescriptions, physical exams, x-rays, outpatient hospital visits, emergency room visits, and inpatient hospitalization. If a primary sponsor exceeds these standards, and if the Department of Social Services and the medical societies determine that there were no extenuating circumstances, then the sponsor might be issued warnings, have his case management fee or his Medicaid payments for services reduced, and/or be disenrolled from the plan.

Sponsors will receive a case management fee of $3 a month per enrollee, and will be reimbursed on a fee for service basis. The physician will not be subject to any financial risk. Any savings experienced through PPSP because of reduced doctor shopping, emergency room visits or inpatient hospitalization will be shared with the physician through fee increases.

PPSP has three potential weaknesses which may create problems. First, any physician in any ambulatory setting can act as a primary sponsor. Safeco's UHC experience suggest that opening the role of primary sponsor to any physician may be unwise because styles of practice differ markedly across specialties. Some specialists may have a tendency to overutilize certain expensive procedures and options. Further, allowing outpatient departments to serve as primary sponsors may reduce savings significantly, particularly if their behavior is at all reflective of the Maryland experience (see pages 37-38). Second, failure to put the sponsor at risk may reduce his sensitivity to and control of referrals of inpatient hospitalization or for that matter the costs and utilization of his non services. Finally, the size of PPSP and the speed with which it will be implemented may lead to many unanticipated problems which in turn might lead to an early death of the project.

These problems may be overcome somewhat by the mandatory enrollment aspect of the program and its standards of care requirements. Mandatory enrollment not only prevents recipients from circumventing the system, it effectively locks in the physicians. If primary care physicians wish to participate in Medicaid, they have to join PPSP or an HMO. If they join PPSP they have to accept the standards of care requirements. If those standards are carefully established, PPSP will be a forceful vehicle for altering the behavior of high volume Medicaid providers. Medicaid mills, for example, should not do very well in this PCN. The big question, of course, is whether the PPSP can secure sufficient participation by physicians willing to be sponsors. If that participation is not forthcoming, MCP will not become operational.

H. Physician Based Group Plan of Baldwin County, Georgia

The Primary Based Group Insurance Plan of Baldwin County, Georgia (PBGI) will become effective in 1982. Unlike the other PCNs discussed, this one will operate solely in a rural setting, will initially cater only to the elderly Medicare beneficiaries, and will charge beneficiaries a premium based on their physician's fee schedule and cost experience. The PBGI concept and plan was developed by Frank Evans, a Baldwin County physician.[31] All 15 primary care physicians in the county have agreed to participate in the plan. The county's 3000 Medicare beneficiaries will have the option of joining.

PBGI attempts to carefully target and isolate incentives on beneficiaries and physicians. Each primary care physician submits his fee schedule for a 12 month period. PBGI then makes an actuarial calculation of the predicted medical costs that will be incurred by that physician's patients. That calculation is used to set that physician's monthly premium. The premium includes the services provided by the physician and a portion of the cost of primary care physician's referrals and the hospitalization of his patients. The referral subsidy is 75 percent of the cost of covered services not directly provided by the primary care physician. This subsidy is intended to assure that physicians will make necessary referral but will also be sensitive to the costs incurred. In addition, physicians are protected by a Catastrophic Insurance Subsidy which covers 90 percent of all costs in excess of $2,000 for an individual patient.

Once the premium is determined, Medicare beneficiaries then choose their primary physician who will manage all of the patient's medical care and authorize all non-emergency services. The choice of physician will depend, in part, upon the physician's premium, pre-existing relationships, and the health of the beneficiary (a sick patient receiving satisfactory care from a physician is likely to wish to continue to receive that care).

Medicare will make fixed contributions to the premium. The client will pay or receive the difference between that fixed amount and the premium of the selected physician. The client will also pay a monthly prepayment for any deductible or coinsurance charges the patient might incur during the year.

The deduction prepayment will cover all deductions and coinsurance charges (except those for self referral), even if the actual charges exceed the prepaid amount. If the

patient does not incur those fees, the unused portion of his "Deductible Account" will be returned to him. Further, if the beneficiary's physician's expenses are less than projected, all or a major portion of the unspent premiums are returned to the client. According to Frank Evans, this approach should be attractive to Medicare eligibles:

> First, by choosing a less expensive physician, he not only saves money, but he also forces less efficient physicians to pay attention to costs. Second, full payment of all costs in advance will relieve the anxiety many patients have over the uncertainty of their Medicare coverage. Third, patients will avoid the frustrating task of filing insurance claims. Finally, since the patient pays his premium in advance, there should be little opportunity for disasgreement over money between patients and physicians. This should strengthen the relationship between the patient and his physician.[31]

These advantages apply only if the client bears some financial risk for his future expenditures. If he is in a Medicaid program which does not place him at risk, these issues become irrelevant from the client's perspective.

The PBGI has a number of features which encourage physician participation. First, he may set his own fees. Second, he will be paid a small management fee of $30 per patient per year. Third, payment for his claims will be made using a "sight draft" system whereby he writes himself a check for his services using the Plan's sight draft form. This system results in immediate payment without bad debts or collection expenses. The sight draft form also serves as the insurance claim and eliminates the cost of filing insurance. Finally, the plan depends upon competition to control costs and as a result has minimal amount of regulations.[32]

In terms of the Medicaid program, there are several characteristics of PBGI which may temper its applicability to Medicaid. The plan is very complex. The presentation above is a simplification of how PBGI will operate. PBGI may not be more complicated than the fee-for-service system but in terms of the actuarial work, the accounts which must be maintained and the costs which must be tracked, PBGI may be equally if not more complex. States must be willing to invest in the front end development necessary for this plan. As was noted above, it is unlikely that very sick patients will change their physicians. If for any reason there is a concentration of sick patients among a few physicians, their premiums will be higher than their competitors regardless how efficient they are. The higher premiums, in turn, could encourage healthy beneficiaries to select less expensive doctors. This process of adverse selection could distort the competitive dynamics of the PBGI. Finally, PBGI depends upon the consumer having a financial risk in

his selection of a physician. A perennial problem in the Medicaid program has been how to structure that kind of risk with a poverty population in such a way that it was not punative and lead to the denial of needed care.

IV. MEDICAID CONTRACTS WITH PCNs

Many of the issues facing states which might contract with PCNs are similar to those they face with any HMO. However, while similar, they are not identical. Therefore this section examines negotiable aspects of a contract with a PCN in nine areas: eligibility, benefit coverage, marketing and enrollment, physician participation, case management, quality assurance, reimbursement, data systems and the role of the state in operating the PCN. Issues shall be presented as questions since in most instances there is insufficient empirical evidence to make firm recommendations.

A. Eligibility

Should the entire Medicaid population be allowed to enroll in a PCN or should it be restricted to specific categories? If the PCN is a new organization, it may be wise to sign an initial contract for the least problematic and least costly of the Medicaid clients, namely, the AFDC categorically needy. Other categories could be phased in as the state and PCN adjusted to the Medicaid relationship. How should joint program responsibilities be dealt with? For example, should the Medicare buy-in recipients be billed as fee-for-service clients with Medicaid's portion of responsibility for care paid on a capitated basis or should special arrangements be made with the Medicare program as well? The eligibility process can create difficulties simply because it often forces rapid turnover in eligibility. This in turn forces disenrollment. Should all PCN enrollees be guaranteed a minimum length of eligibility? Does the cost of that guarantee exceed the cost of the PCN marketing to compensate for newly ineligible clients and the cost of inducing the PCN to participate in the program. Since eligibility redetermination is a recurring problem in many HMOs with Medicaid contracts, should eligibility be guaranteed and enrollment in the PCN be maintained for at least a month after the redetermination is made (or the minimum time for a client to become eligible again if he was determined ineligible solely because he failed to show up at the welfare office for the redetermination). Can eligibility determination workers be trained not to automatically issue Medicaid cards to clients claiming to have lost their cards? This has frequently resulted in clients either being automatically disenrolled from the PCN or having the use of both fee-for-service providers and the PCN.

B. Benefit Coverage

Should the PCN offer the full range of Medicaid benefits? What kind of guarantees should the PCN present the state to assure that it has the capacity to provide the promised care? Should PCN benefits be greater than benefits set forth in the state plan; e.g., should they include health maintenance services? Should benefits be less? If so, would that require two Medicaid cards: one for PCN services and one for non-PCN care? Should clients have an option of a number of PCN plans similar to the HMO options in Project Health or should benefits be uniform throughout a geographic area?

C. Marketing and Enrollment

Should the enrollees have the option between fee-for-service or PCNs? Should enrollment inducements be offered such as the monthly fee paid to Massachusetts Case Management enrollees, the guaranteed length of eligibility provided to the Santa Barbara Health Initiative enrollees or an increased benefit package vis a vis the fee-for-service option? Or does the option of fee-for-service or PCN create too many marketing problems and too many opportunities for adverse selection? Should clients therefore be given only a PCN option as is currently being considered in Michigan and done in Santa Barbara? Should the PCN market the plan or the state on behalf of the plan? In California there is evidence that the welfare councilor can market an HMO more successfully than the HMO and at one third the cost. Will the federal interpretation of Group Health Plan of Northeast Ohio as an extention of the state, and therefore not restricted by the Privacy Act, be extended to all PCNs? Would access to the name and addresses of all eligibles within the PCN catchment area make the PCN a more effective marketing agent than the state?

D. Physician Participation in the PCN

Should the designation of primary care physician be restricted only to general practioners and family practice physicians or should it be open to any physician willing to act as a primary care physician? Should restrictions be placed on primary care physicians and specialists? For example, should physicians with histories of questionable practices within Medicaid be allowed to join a PCN or, more directly, be allowed to serve Medicaid clients? Should outpatient departments be allowed to serve as a primary care site or does their affiliation with a hospital somewhat subvert their role and produce a disproportion-

ate amount of referrals and hospitalizations? Should primary care physicians be allowed to have both fee-for-service and PCN clients? If so, should they be also allowed to enroll clients? Would this create an incentive to cream-skim by enrolling only the low cost clients? Should the state offer inducements to physicians to join a PCN?

E. Case Management

Should the primary care physician have absolute control over the client? Are there situations other than emergencies and out-of-area medical problems where self-referral is justified? How should the PCN deal with self-referral: non-payment for non-approved services, after the fact payment, and patient education and/or disenrollment of an intractable client? What is the minimum time period that a client should be locked into a primary care physician? (This is a different issue than a minimum period of guaranteed eligibility.) What should the grounds be for changing a primary care physician? How does the PCN determine whether or not the primary care physician is performing his case management function adequately or properly? Are there measures of underuse or overuse of specialists, hospitals or drugs? It is possible that the PCN may inadvertantly allow poor case management at no risk to the primary care physician? Should the state require that the PCN provide the supports necessary for good case management; e.g., a cost and utilization reporting system which allows a primary care physician to compare his practice to other similar practices as well as allows the physician to make informed decisions about specialists, hospitals and other providers? Should the primary care physician be paid a fee for case management or simply be placed at risk with the fee implicit in a capitation rate; i.e., if he manages properly, is he rewarded?

F. Quality Assurance

What are the minimum quality control mechanisms acceptable to the state. Should the PCN be required to design a data processing system which flags abherent behavior? Should it be required to convene its own peer review committees? What powers should be lodged with the PCN Medical Director? Should the state have direct and immediate access to all of its clients' medical records? How should clients be allowed to voice their grievances? Should the state be part of the grievance procedures?

G. Reimbursement

How should the capitation rate for the PCN be set? If it is a percentage of the fee-for-service experience, should the fee-for-service costs be estimated by compiling the historic fee-for-service costs of the individuals prior to their enrollment in the PCN and trending that figure forward or should the capitation rate be based on a matched fee-for-service population? Are age, sex and program adjustments sufficient in setting the capitation rate? What other variables are strongly correlated with utilization and costs? If the primary care physician is capitated, should the state become involved in setting that capitation rate or evaluating how reasonable the rate is? Speculating on the problems of doing this, Holahan and Feder have noted that, "if the system is to save money, the cost must be less than the total cost under fee-for-service. But if a state's physician (Medicaid) fees have been historically low relative to private fees, as they have been in virtually all large states, capitation rates must then be low. If they are too low, it will be exceedingly difficult to attract physicians to a system containing many unknowns. The state has thus relatively little room for negotiation and great care must be exercised to achieve both participation and lower program costs."[33]

This dilemma exists only if the state is concerned about minimizing the primary care physicians capitation rate and not the total rate for all the services provided by the PCN. It should be stressed that it is not clear whether the primary care physician should be capitated, paid on a fee-for-service basis or a combination of both. Further if a risk arrangement is agreed upon, should the primary care physician be at risk only for his own services? For referrals? For hospitalization? For other goods and services? How should risks be limited? When should reinsurance for catastrophic illnesses become effective? Should reinsurance thresholds vary with the number of PCN enrollees in a physician's panel? Should reinsurance be tiered as it is with Group Health Plan? Should excessive average costs be limited again as they are in Group Health Plan through loan arrangements (an effective offset of losses against future profits) or through reinsurance? Should total PCN savings (or profits) be distributed among the primary care physicians? If so, how? Should the PCN be allowed to take advantage of the Medicaid's hospital and nursing home discount? Should Medicaid dictate reimbursement for any or all providers in the PCN?

H. Data Systems

Once answers are negotiated to the previous questions, will the state or the PCN have the data system necessary to implement the contract? Current data systems are often not integrated, not centered around the primary care physician, and not geared to monitor both under and over utilization. If the state and the PCN do not have synchronized data systems up, portions of the PCN program may be completely shielded from inspection or review, something which could damage the PCN or compromise the state's understanding of the agreement.

I. The State Agency as the PCN

A state may decide that it would like to act as the PCN and write contracts directly with primary care physicians and all other providers who would participate in the network. This would require that the state resolve all of the issues raised above. It would also require that the state continue to monitor and reimburse the same number of providers that it currently does under fee-for-service. The state may also have to set up special regional offices capable of administering each local PCN because any attempt to control a statewide system from a central office may be doomed. PCNs require careful monitoring of each primary care physician which may be impossible from one central office. Finally, the state may have to create a special legal entity to administer the PCN. This is not necessarily a problem but it does require careful preparation and may hold up the implementation of a state run PCN.

On the positive side, if the state directly managed its PCNs, it would keep the financial reserves which it would invariably contribute to in an independent PCN. The state might have greater access to information. And, it might be able to resolve bureaucratic in fighting at state and county levels more easily than an independent PCN. Unless a state has had experience with HMOs or other PCN type organizations, the prudent approach may be for a state first to contract with a PCN, work out all the kinks in that arrangement and then attempt to set up a state run PCN.

V. CONCLUSIONS

PCNs are an evolving form of health delivery. A large number of questions and issues have not been answered. There are, however, three elements which seem to be essential to any state involvement with a PCN. First, there must be close cooperation between physicians and the PCN. If that is absent, the PCN may be unable to control or monitor its physicians and the plan can run into severe problems. Second, not all physicians should act as primary care physicians. The criteria for physician participation and the standards for acceptable performance must reflect the PCN's goals and expectations. Finally, the PCN must have the capacity to monitor its physician's behavior and to provide its physicians with timely and accurate information concerning their cost and utilization experience relative to other members of the PCN. The failure to do this means that the PCN may be running blind and the primary care physicians will certainly be unaware of how they compare to other physicians and how they fit into the overall operation of the PCN.

Nonetheless, PCNs seem to be the most promising means for "introducing" competition into the market, altering expensive and inefficient incentives in the delivery system, and providing care in a manner consistent with public policy. PCN's are an option that every state may wish to consider as states attempt to adjust to a new period of public scarcity.

FOOTNOTES

1. For example, see "Report and Recommendation by the Maryland Task Force on Primary Care Services," October 1981, and Diane Nassiff, "Utilization of Medicaid Services by AFDC Recipients in Massachusetts," Massachusetts Department of Public Welfare, Boston, Massachusetts, November 1978.

2. Bruce Spitz, State Guide to Medicaid Cost Containment, Second Edition, Washington, DC, NGA/IHPP, November 1981.

3. Barbara Blum, Russell Schwartz and Martin Roysher, "Utilization of Health Services by NY City Recipients, 1979-80," Albany, NY, NY Department of Social Services, September 1981.

4. Thomas Singleton, "Missouri Lock-In: Control of Recipient Misutilization," Journal of Medicaid Management, Vol. I, No. 3, Fall 1977, pp. 10-17.

5. Clark Havighurst, "Health Maintenance Organization and the Market for Health Services," Law and Contemporary Problems, Vol. 35, Autumn 1979, p. 770.

6. Personal communication with Peter Fox, Ph.D., Lewin & Associates, Washington, D.C.

7. Michael Reddisch, "Cost Containment and Physician Involvement in Hospital Decision Making," Washington, DC, Social Security Administration, Office of Research and Statistics, 1977.

8. Bruce Spitz, op cit.

9. John Holahan and Judith Feder, "Medicaid and Capitation Payments to Physicians, The Urban Institute, Washington, D.C., undated.

10. Ibid.

11. This section summarizes the article by John Cirn, "Physician Response to the Formal Referral Policy of a Blue Shield Capitation Plan," Journal of Family Practice, Vol. 13, September 1981, pp. 5-13, 521, and interviews with members of the Wisconsin Physician Service.

12. Paul Simenstad, "Health Maintenance Plan of the Wisconsin Physicians Service," presented at the National Governors' Association Conference on Medicaid and Primary Care Networks/Case Management Systems. New Orleans, Louisiana, December, 1981.

13. John Cirn, "Physician Response to the Capitation and Formal Referral Policy of the WPS Health Maintenance Program," unpublished, undated.

14. Stephen Moore, et al, "Cost Containment through Risk Sharing by Primary Care Physicians: A History of the Development of United Healthcare," Health Care Financing Review, Spring 1980.

15. Interview with Diane Martin, Project Director of the HCFA grant to the Study UHC and the state employees using UHC.

16. Stephen Moore et al, op cit.

17. Roswell Bond, "United Healthcare" presented at the National Governor's Association Conference on Medicaid and Primary Care Networks/Case Management Systems. New Orleans, Louisiana, December, 1981.

18. Interview with Robert Gregory, former director of UHC.

19. Maxwell Davis, DDS, "Group Health Plan of North East Ohio" presented at the National Governors' Association Conference on Medicaid and Primary Care Networks/Case Management Systems. New Orleans, Louisiana, December, 1981.

20-21. Medical Group agreement between Group Health Plan and participating physicians. 1980 contract.

22-23. Department of Human Services, Multnomah County, Oregon, "Demonstration Proposal: Intake Health Screening in the Context of a Competition Model Consumer Choice Health Plan for Publicly Funded Beneficiaries," October 5, 1981.

24. Blum, Schwartz and Royscher, op cit.

25. Lyda Sanford, "Maryland's Plans for Implementing Primary Care Networks" presented at the National Governors' Association Conference on Medicaid and Primary Care Networks/Case Management Systems. New Orleans, Louisiana, December, 1981.

26-28. Massachusetts Department of Public Welfare, "Case Management as a Cost Effective Approach to Improved Health Services Delivery to Medicaid Recipients," Boston, Massachusetts, July 30, 1981.

29. Office of Health Delivery Systems, Santa Barbara Health Care Services, "Demonstrating a County Sponsored Prepaid Medicaid Program in Santa Barbara," undated.

30. Bruce Hansen and Sherry Wellman, "Michigan's Physician Primary Sponsor Plan" presented at the National Governors' Association Conference on Medicaid and Primary Care Networks/Case Management Systems. New Orleans, Louisiana, December, 1981; and "Physician Primary Sponsor Plan" Department of Social Services, Lansing, Michigan (undated).

31. For example, see Frank Evans, "Physician-Based Group Insurance: A Proposal for Medical Cost Control" New England Journal of Medicine, 302:1280-1283, June 5, 1980.

32. Frank Evans, "Physician Based Group Plan of Baldwin County, Georgia" presented at the National Governors' Association Conference on Medicaid and Primary Care Networks/Case Management Systems. New Orleans, Louisiana, December, 1981.

33. Holahan and Feder, op cit.

PANEL ONE:

PRIVATE SECTOR EXPERIENCE WITH PRIMARY CARE NETWORKS (PCNs)

Included in this section are the presentations by the following representatives of organizations which have operated health care delivery and reimbursement systems based upon the PCN or physician specialty referral model.

Safeco's United Healthcare

Roswell Bond
Former Chairman of the Board
United Healthcare, and
President, Safeco Life Insurance Company;
Currently President, Healthnet Management

Wisconsin Physician Services

Paul O. Simenstad, M.D.
Medical Director, Wisconsin Physicians Service

Group Health of Northeast Ohio

Maxwell Davis, D.D.S.
Executive Director
Group Health Plan of Northeast Ohio

Middle Georgia Medicalcare

Frank Evans, M.D.
Vice-President,
Middle Georgia Medicalcare

SAFECO'S UNITED HEALTHCARE

Roswell M. Bond
President, Healthnet Management
Formerly
Chairman of the Board United Healthcare and
and
President, Safeco Life Insurance Company

Bruce Spitz' paper is an excellent one and I urge you all to read it. Not just because it talks about what I've been involved in for a number of years, but it's a very good summary of what's going on from a primary care standpoint. In that paper, he tells the United Healthcare story, so I am not going to get into that to any great extent, except to perhaps explain a few things.

There are two unique aspects of United Healthcare's operation. The first is that each doctor in UHC had a separate account. Each one of our primary care doctors in fact was a little HMO unto him- or herself. They operated out of their own account. The other item of difference already mentioned was that we finally ended up using a specialty panel. These are the two major differences between United Healthcare and other plans.

With respect to this first difference, I'd like to explain the financial model within which each individual primary care doctor worked. Let's assume that a doctor had 100 patients. In today's cost environment, 100 patients would generate approximately $40,000 of annual income that would flow into the doctor's account. It is not a capitation account. Actually, we found it somewhat difficult to capitate our doctors. We set this up as a bookkeeping account, and we would put the $40,000 into that doctor's account. Out of that account all medical costs were paid and charged against the account. The primary care doctor was compensated at 95% of their normal fee-for-service and was paid on that basis. The referred care was paid originally at normal fee-for-service for specialty care hospital, etc. One of the changes we made was to set up a specialty panel, and they were then reimbursed on a fee schedule basis. You can see that about 20%, on the average, of the income was going to the primary care doctor, the other 80% to the referral care. The doctor here was at risk only in relation to the income that they received. The downside risk was about 80 cents on the dollar, or 20% ($1600) potential downside risk, the upside

risk in an unusual situation where they could get the full financial incentive was about $4,000 or 50% of what their primary fees had been.

If this was such a good approach, why did Safeco decide to shut it down? I think that unfortunately this was a matter of timing. We discovered our basic problems in very late 1979. We knew we were in trouble. We identified the financial impacts of those problems about the middle of 1980 and the basic decision to get rid of United Healthcare was made in December a year ago. We were experiencing bad financial results. This experience manifested itself about four to six months before most other health care carriers experienced the same kind of things. I would mention that Safeco's group operation at the end of nine months lost over $2 million on its health insurance operations. So I think United Healthcare got there a little bit quicker than other people, and unfortunately the decision was made on that basis. Another point here was that United Healthcare was a very, very small part of Safeco corporation which is basically not a health insurance carrier. They're basically in property and casualty and other insurance lines. From a corporate priority standpoint United Healthcare did not occupy a terribly important position.

As I mentioned in late 1979 we knew we had problems. We were able to identify what they were in early 1980, and draw up an action plan about this time a year ago. Because we had to change contracts and we had to change our relationship with a number of our doctors, it took about six months for that to be accomplished. So actually our changes did not really take place until late spring and even early summer of 1981.

As far as my situation is concerned, when Safeco decided to get rid of United Healthcare, I decided I would like to go along with United Healthcare because I felt that we were on the verge of accomplishing what we had set out to do. It was an unproven concept that had evolved over a ten year period. We had learned a lot, and we felt that we had just about gotten over the hump and would start to see some success.

There were three basic failures on my part and management's part in terms of what we did at United Healthcare. First of all, we got a tremendous amount of national recognition. Bruce in his paper writes United Healthcare was the best known primary care network. I don't know whether we were the best known, but we certianly had a lot of opportunity to travel around all over the country, even down to Australia to consult with the Australian government on how we were doing it. While we were traveling, things were

deteriorating at home. Any state that comes up with a creative solution to its Medicaid problems, better watch out for that. Stay home. I instructed the President of United Healthcare in late 1979 that he and his lieutenants were to stop traveling. It was then that we started to address our problems; unfortunately, as far as Safeco was concerned, it was too late. As far as I'm personally concerned, maybe the timing was just right.

Our second mistake was that we were not communicating properly with our doctors. We had originally gone to the primary care doctor and said, "We're going to put you back in control of medical care." They responded that they liked the idea and would assume the responsibility. Then we turned our back on the doctors and we went and did other things. You cannot do that. Doctors are just like you and I; they need to be communicated with. They need to be shown where they are going astray, what they are doing right, reinforcement. We were not doing that. We were not communicating with them. We failed to find out from our doctors how their mindset was changing as they gained experience in trying to manage health care.

Our third mistake was that we were accumulating an outstanding set of data out of our claims processing and our encounter forms, but because United Healthcare was very low on the priority list, we had extreme difficult in accessing that data through Safeco's data processing department. It was there but we couldn't get to it, we couldn't question it. The ability to query your data is absolutely essential (as you have ideas as to what's going on--you need the ability to get to it and test the idea and see if you're right or wrong). Access to your data is also essential in terms of your communication with your doctor network.

Finally, we got access to our data. What did we find out? First, we found out that we were providing too liberal a benefit. We were providing very comprehensive benefits in a community that was already providing comprehensive benefits to start with. We had even improved upon it. This led to some anti selection. We were particularly getting tapped in areas such as in-patient mental and nervous care, and alcoholic treatment programs on an in-patient basis.
primary care physicians. All doctors who say they are primary care physicians are not necessarily so!

Probably the most important, however, is we had lost control of specialty care. When we had first gone to our primary care doctors, they had told us, "yes, we will

control." But the fact of the matter is that no, they wouldn't control and they couldn't control and they didn't want to control. Because they had lost control of specialty care, the specialists were operating very much the way they had always operated, without much constraint. The specialist's workshop is the hospital, and as our specialty cost went up, our hospital costs went up. We are in a rather sophisticated medical community: medical school, a lot of research, a preponderence of specialists, and in fact the specialists intimidated the primary care doctor, and the primary care doctor said, "I really can't control the specialist, but if you will control the specialist, we will go along with it.

So what did we do to correct these problems? We went to the primary care doctors and asked them to tell us who they would like to refer to. Very briefly we then took that list and went to the doctors that were mentioned most frequently and said, "Mr. Specialist, you have been selected by your peers to be their representative on a specialty panel. We would like you to participate, but if you do, you must agree to accept a certain fee schedule; you must agree to meet with other doctors within your specialty to establish criterion for care, both as to when you will confine and what can be done outpatient; and then if you do confine, how long patients will be in the hospital under normal circumstances. We established the use of a referral procedure that stipulated that no specialty care would be compensated by United Healthcare unless it was delivered as a result of a referral form from the primary care doctor.

We mandated use of the referral panel. We went to our primary care doctors and said you must use this panel of specialists. This separated some doctors from the primary care list because they said they just could not do that. "You're fooling around with something that is too sacred to me." By and large most of our good primary care doctors said "I will give it a try." Actually, I think they have found that they like it. A part of the reason it's worked out is that we have some of the very finest specialists in Seattle that are recognized by the medical community as the best specialist within their field.

We also set up concurrent hospital review. I could call Seattle right now and find out who was in the hospital for United Healthcare yesterday in every hospital in Seattle. We were monitoring all hospital care while people were in the hospital, and if they were in the hospital beyond the expected stay, we would find out why. In fact, we literally moved people out of the hospital or we told them we weren't going to pay for any more care because their doctor said that, medically speaking, they were able to go home.

Then we changed the benefits. We put a $50 deductible on emergency room care for some of our largest cases in order to keep people out of the emergency room for primary care. We went to a standard insurance contract for mental and nervous with 50% co-payment, and we instituted a $2500 annual maximum for in-patient alcoholic treatment, and we required that the treatment program must be completed. We found that a lot of people were going into the facility; they were getting detoxified and discharging themselves about halfway of two-thirds through the program, and they were not completing the program. This change has had a dramatic effect on the use of this care.

What are the results? Specially care and primary care should be very close together if we are going to be financially balanced. In January of 1980 we were spending about $31.50 per month per enrollee. We reached a high in March of 1981 of about $44 per month (considerably more than our premium income at the time). We instituted the changes that I have mentioned--the specialty panel, changing benefits, reducing the doctor network--and we experienced a dramatic drop in the cost of care during July and August. The cost has come back almost to where it was 20 months ago, and this is not on an inflation adjusted basis. These are 1981 dollars. These are figures Safeco did not have available to it when it made it's decision to divest United Health Care.

That tells the story. In our opinion there are only two ways to affectively control health care costs over a long period of time: first, getting people to change their life style--health education, if you will. We've all heard a lot about it. I happen to believe in it, but it is a long-term strategy. If you were to implement a program today, you might not see measurable results even in five years. But it will work. The other approach to controling health care costs is to control the factors of health care production--and the major factor of health care production is the doctor. Bruce mentions it in his paper, he says 75% of care is channeled through the doctor. I say 95% of the care that you are paying for and that we are paying for is channeled through physicians. Unless you can control physicians, you cannot control costs.

HEALTH MAINTENANCE PLAN
OF THE
WISCONSIN PHYSICIAN SERVICE

Paul O. Simenstad, M.D.
Medical Director
Wisconsin Physician Service

The Plan

The Health Maintenance Plan, or HMP, was originated by Wisconsin Physicians Service, a Madison, Wisconsin Blue Shield organization which also markets standard medical and hospital insurance plans. Since the inception of the plan in Wild Rose, Wisconsin, a small rural town, in October of 1970, it has grown from 219 participants to 182,000 participants who are taken care of by over 1,900 physicians in 62 of the 74 counties in Wisconsin. The counties do involve several metropolitan counties but not the metropolitan Milwaukee area. Many of the 1,900 physicians are in group practice, which is a common form of practice in Wisconsin. This is especially true in Madison, where approximately 80,000 participants reside. Sixty-five percent of the care of these 80,000 participants is done by 7 multi-specialty clinics.

The Purchasers

Some of the larger purchasers of insurance, such as the State of Wisconsin and others, have special arrangements with Wisconsin Physicians Service. Seventy thousand of the 182,000 participants are State of Wisconsin employees. The state has an administrative service contract only with Wisconsin Physicians Service for HMP, and the insurance carrier works closely with the State Group Insurance Board in approving benefits and making final decisions about the plan. There also is currently a plan for a consortium of Madison City, Dane County, and Madison School Board purchasers to work together on problems with the insurance company, WPS. Other industries have not had working arrangements as the purchaser with the insurance carrier.

Relation to Physicians & Medical Society

HMP has been developed through physician input, and in Dane County the Medical Society provides a steering committee of 6 physicians; and the Society approves guidelines for the operation of the plan on a yearly basis. There always has been an agreement with WPS and the Society; and considering the length of time since the plan began, even a

negative vote by the Society would not stop the plan's function, as most physicians would continue to sign up with the program even though there might be criticisms of it from the Medical Society. This has not happened to date. WPS also has physician input through a consulting Medical Advisory Group which represents all specialties. These physicians are available to the carrier on a consultation fee basis for medical claim adjudication for HMP claims and also for standard insurance medical claims.

There are 4 main providers of service under the plan, and from year to year the guidelines have been modified as they apply to these groups.

Primary Physicians

Patients must choose a primary care physician (or clinic) who is paid a monthly Health Maintenance Fee. This monthly capitation fee is based on the provider's previous year's posting and is adjusted every 4 months. The capitation fee is of course only part of the individual participant's monthly possible expense to the program. Charges may come in during the month for an individual for hospital care, outpatient medical care, drugs, and care by other referral physicians. Payment for these charges and for the HMP capitation fee are drawn from the primary physician's Health Service Fund maintained by the insurance carrier. Unlike other plans such as SAFECO, there is no formal approval by primary care physicians for other charges by referral physicians before they are paid out of the health service fund by the insurance carrier. There also has not been a monthly status report given to the primary physician or the clinic on payments out of this fund.

At the end of the year there could be a deficit or an excess in the Health Service Fund for each provider, meaning an individual physician or a clinic. If there is a deficit, the physician or clinic is not at risk greater than 12% of the deficit in the fund at the time of final accounting. The provider cannot have his payment be reduced less than 88% of his charges that he puts on his books.

If there is an excess in the fund at the end of the year after the capitation fee and all charges are deducted from the fund, the physician or clinic might be entitled to an incentive payment based on 12% of the remainder in the fund but not to exceed 100% of the individual physician's or the clinic's actual charges.

Generally, primary care physicians, both as individuals and in clinics, have been happy with the program. The Health Maintenance Plan in Madison may account for 10-

40% of a primary care physician's income, depending on his mix of state, city, county, and school board employees plus other HMP patients. Outside of Madison, HMP represents a smaller percentage of a physician's total practice.

Referral Physicians

Self-referral by a patient to any specialist is not permitted. The primary physician's responsibility is to determine with the participant patient whether a referral service is indicated. The participant patient shall have free choice as to which specialist will be seen. The primary physician usually guides the referral, as would be expected, because of the patient's lack of information on the various referral specialists. However, to avoid antagonism in the medical community, it has worked out well for the primary physician and the patient to agree on the specialist to be consulted. Often patients already have known about other specialists in the community and are free to see them and continue a previous relationship.

The referral specialist who has signed on with the program will have an instant payment by way of a bank sight draft mechanism. Because there is no billing expense, there is a 6% discount for this service.

Generally, referral physicians have also been happy with the program, partly because they realize that many of the patients will have HMP; and it is one of the major sources of patients, at least in Madison. Also, they have accepted the fact that they will not automatically be blocked from seeing patients if the patient chooses them.

Non-Participating Physicians

Payments to non-participating physicians are paid on a usual and customary and reasonable basis as determined by the insurance carrier through its standard insurance fee-for-service information. Payments to referral specialists and non-participating local physicians are charged against the primary physician's health service fund as mentioned earlier. However, WPS as the insurance company also keeps out some premium money in a separate fund for all emergency and all out of area charges which might come in. This fund also is available for very large charges called shock loss charges. Twenty percent of total premiums are kept to cover WPS reserves and administrative expense plus emergency, out of area charges, and the large shock loss items. If the latter category of a participant's illness charges are greater than $7,500 to the program, this payment is made from this fund of the insurance company rather than from the individual physician's

health service fund. In other words, large charges and out of area charges are charged against the program as a whole rather than against the Health Service Fund of each provider.

Hospitals

There is a problem in having hospitals be at risk in the program. They have agreed to a payment discount of 1 percent because they are paid on sight draft or instant money. There has been some resistance recently when it was suggested that this discount be raised to 2 percent. Generally the hospitals have been little affected by HMP. It has been business as usual for them, even though 50-60% of the HMP funds are paid to them. There have been some beginnings at trying to combine cost-effective programs with physicians and their hospital as far as HMP patients are concerned, but this has not succeeded to any degree at this time.

In summary, the HMP program has been effective for 10 years. It was originally intended that it would allow free choice of physician and be superimposed on the existing health care financing system. Also it was originally felt that the primary physician should be the manager or gatekeeper, and referral to other physicians would have to be on a formal basis. These original goals of the program have been maintained.

Current literature on HMO's or primary care networks has suggested that in order for a program to be successful it should have committed leadership by physicians. This has been certainly true in Wisconsin, especially in the Madison area. Other literature has suggested that there be rigorous professional review, and this has not really been done in the Wisconsin plan. Also, there has not been rigorous hospital review, nor has there been physician certification that they are cost effective.

Why Is The Health Maintenance Plan of Wisconsin Physicians Service Reasonably Effective?

Considering the fact that it is a state-wide program, it is somewhat surprising that the program has been effective. Actually, HMP insurance is offered to state employees and other government employees at the same cost that they would pay for standard insurance. One of the reasons that it has been successful is that it is a large program, thanks to the purchasing of the State of Wisconsin and other governmental agencies. Also, the program has been primarily in rural areas and in small cities. The Dane County-Madison area has 300,000 people. However, there are large clinics which have extensive

outpatient facilities; and this probably is one of the reasons that it has succeeded. WPS at one time was an arm of the State Medical Society and has had basically good relationships with the physicians. There are enough primary care decision makers in the state to make the program effective. WPS as the insurance company has worked hard on professional relations with the physicians, and many of the suggestions to run the program come from the physicians. It is very important that there are large group practices in place which have full lab, x-ray, and physical therapy; and therefore hospitalization often is not considered as quickly as it might be in other areas. Other factors that have made the program go is that generally there has been fairly good cost consciousness in the State of Wisconsin, and also fees in the upper midwest area have been slightly lower than they have been nationwide. The quality assurance and utilization review programs in the hospitals have been effective, and also WPS has paid for concurrent care review on utilization problems in the hospitals.

The following cost containment programs have not played a part in the program. There has been no hospital voluntary effort and very little pre-admission testing. Also, second opinions have not been used; and there has been no reduction in bed capacity. There has also not been much fear of competition from a staff-salaried group HMO. However, this factor may be increased at this time. There has also been no screening to remove high utilizers in the patient population or to remove physicians who are not cost-effective from the program. There have been some gentle pressures on certain physicians and groups to be more cost-effective; and when this has been done, there has been an improvement in their practice patterns.

Probably the insurance carrier, WPS, could be sending out more timely reports on utilization and cost to keep the providers more interested in cost-effective medicine. There is a year-end audit which settles up the finances of the program. There have been no negotiated fee schedules with the providers and the insurance company. However, generally both Blue Shield companies in Wisconsin have announced that they would limit too high increases in fees from year to year.

In summary, the Health Maintenance Plan of Wisconsin Physicians Service has been a successful primary care network plan. Some have said that it is mainly a glorified fee-for-service plan. However, it has been evolving slowly over a 10 year period with great acceptance, both on the part of the patient and on the part of the providers. It is important to remember that free choice of physician has been preserved, and the program

has actually given more benefits than do standard contracts by the same insurance carrier. Also, there has been a switch from a 60% payment for hospital care and 40% for outpatient to about 50% in each area over the last 10 years. It is hoped that it can continue to evolve as an attitude toward better care for all patients and not only an administrative service to reduce costs or to control the health care industry.

GROUP HEALTH PLAN OF NORTHEAST OHIO

Maxwell H. Davis, D.D.S.
Executive Director

I have been requested to give a presentation on the experience of Group Health Plan of Northeast Ohio. I want to tell you that we are going to give you a 1-2-3 punch. I, as the Executive Director, will go over some salient facts about Group Health Plan and my observations as to its application to the Medicaid-HMO problem.

Following my address this afternoon, Dr. David Schmidt, who is the Director of Case Western Reserve Family Practice Residency Program, and Dr. John Abramson, a member of the Staff of The Family Practice Program, will be presenting an analysis of their patient population behavior of which a significant portion is membership from Group Health Plan. We feel that at the end of this afternoon, you will have some comprehension as to what we are trying to do.

Group Health Plan's origin was with the original eleven networks funded under the OEO Program. Their purpose was to develop alternative care delivery systems for underserved populations. With the demise of OEO, this process came under the aegis of the Bureau of Community Health Systems of the then Department of Health, Education and Welfare. This was commonly known as the prepaid section of the 330 funding mechanism under the direction of the Bureau of Community Health Services. Group Health Plan became operational in 1975 and during the next few years, underwent some dramatic changes that moved it away from being solely a delivery system for the poor and underserved and thrust it into the full spectrum of the burgeoning HMO movement.

Under very good leadership from Region V of the then HEW in Chicago, and strong community support from both neighborhood community organizations and organized labor, Group Health Plan was able to mature into a full scale HMO. Looking back, I would say that one advantage in the origin of Group Health Plan was in the great diversity of input into its development.

The Group Health Plan Board continues to have definitive membership requirements so that most major components of society are represented. On the Board sit representatives from the health provider segment (physicians, dentists, hospital administrators,

etc.), from organized labor, from the business community, from the underserved community. Group Health Plan's Board also has the provision that a majority of its Board members must be members of the Plan. This has given us a very fine, balanced input and an ability to create programs that are not determined by any one special interest group.

Group Health Plan is a variant HMO model. We quite often refer to it as a third generation HMO. Group Health Plan of Northeast Ohio differs from the traditional models in that all of the physicians and dentists are capitated and they are all primary care providers and they all serve a fee-for-service population. They also are not in a single staff model form but provide this care at various sites throughout the six county area in which Group Health Plan is now operating.

The primary health care provider serves as the manager or "gatekeeper" for all required health care services. For example, in the medical care system, when a member joins the plan he must choose one of Group Health Plan's medical care providers; this could either be a solo practitioner or a group practice. Among our physician providers we have solo practicing primary care physicians (essentially family practice physicians), hospital based family practice residency programs, family practice groups, an internal medicine group, large multi-specialty groups, a pediatric group attached to the University Hospital Medical School complex, and three sites of a primary care neighborhood health center (Hough Norwood Family Health Care Center). This allows for a variety of form and delivery mechanisms and a wide choice from which the potential member can select.

After the member has selected a provider for his entire family, the provider is paid a fixed monthly capitation, which is now at $11.50, and for this he is responsible for the management of the members' health care problems and must also pay for all inpatient and outpatient physician services, all consultants and outpatient lab and x-ray.

The primary care physician receives the capitation monthly and personally issues checks to his colleagues for those services that he has ordered. This is an important part of our "genetic code". This differs essentially from the model utilized initially by SAFECO United Healthcare. We feel it is an integral difference and basic to our survival. If the patient is not referred by his primary care physician, the cost of specialty service is not covered.

Group Health Plan permits the family physician to maintain complete control of the medical care to be provided his patient, enabling him to consider carefully the appropriateness and necessity of all services provided. Any primary care physician willing to assume the responsibility of ongoing patient care may become a provider and see prepaid patients in the same setting as the rest of his practice.

The reimbursement schedule has been updated since 1975 on a regular basis, related to the cost of living. The monthly capitation paid the physician does not vary according to the age or sex of the patient. It is standard for all enrollees and standard to all physicians. The cost of hospital care is provided by the Plan, and not included in the physicians' capitation. At the end of the contract year, the physician will share in any surplus in his allocated hospital pool; but if there is a deficit, he must pay back up to 5% of the capitation paid during the year.

The number of physicians seeking to become members of our Plan has grown slowly but steadily, from an initial five in 1975 to 125 at the present time. The fee-for-service equivalent of the care actually provided is carefully monitored, as is also the quality of care, to guard against under-utilization. Each year the total cost of the care provided is calculated, based on a fee-for-service equivalent. It appears from our statistics that in the average, well-run physician's office, a surplus of 10 to 20% is retained by the physician. This is an incentive to the physician to manage the patient's health care carefully.

The patient is free to select the medical group most appropriate as to location or personality. However, once the enrollee has selected a medical group, all referrals will be at the discretion of that primary care physician. Most of the medical groups are primary care groups, and they often refer the patient to the very consultant whom he would ordinarily choose. No consultants are under contract to the Plan, nor, in most cases, to the medical group. This arrangement encourages involvement of all consultants in the Plan area. The consultant is not aware of the funding source of the patient. Medicaid patients are seen with regular referrals from the medical group. Consultants are paid their usual fee promptly by the medical group and no special billing forms are required. This insures maximum participation and cooperation of physicians in the geographic area.

Utilization by the Medicaid enrollees for the year 1980 was as follows:

At the present time, Group Health Plan is providing care to about 25,000 medical subscribers and 9,000 dental subscribers in a six county area. Approximately 125 primary care physicians are under contract, with a referral network of over 600 specialists, using 45 area hospitals. In addition, 80 contracting dentists are providing care at 42 locations.

The strength of Group Health Plan is that this is a "single door" entry system. All enrollees receive the same card and are not identified to the physician as to the source of their premium. This mechanism has strengthened the patient/physician relationship with the Medicaid patient, bringing the HMO member directly into a system of ongoing health care with a personal physician. We feel this has dramatically improved the comprehensiveness and quality of the medical care received by the Medicaid enrollees. In addition, it has controlled the cost by centralizing the patient's source of medical care, preventing duplication of service or inappropriate use of facilities, such as the emergency room.

Group Health Plan, differing from most HMOs, serves the full spectrum of the population. The poor through Medicaid, the near-poor through 330 Funding, the employee group member, the non-group member and Medicare. Of our membership, approximately 6,500 are Medicaid funded, 2,800 are 330 Funded, 14,000 employee group and the rest, non-group and Medicare. This also allows for a rather unique conversion of coverage system without changing the benefit structure or the primary care provider.

Individuals and families in Group Health Plan have gone from Medicaid to 330 Funding, to employee group and self-pay and vice versa, without substantially altering their benefit package and not changing their primary care provider relationship. Also, in the case of change of residence, the member can select a different site of care closer to their new residence. Another essential element in our design allows the member to transfer provider group upon written request and, conversely, the provider group can ask that the patient be transferred if there is severe incompatibility. This transfer request of the provider group will not be honored if it is based on the medical needs of the member or their family.

The Group Health Plan Medical Information System consists of CRTs that are on line with a large computer owned and operated by Medical Data Systems of Cleveland, Ohio. This provides instantaneous entry and recall of all information. At the time of the visit, the physician fills out a short encounter form, providing information as to diagnosis, medication prescribed, lab and x-rays ordered, referrals ordered, and the relative value of

the services provided. When this data is entered into the system it enables Group Health Plan to monitor the quantity and some aspects of the quality of the health care provided at our various delivery sites. Appropriate information transfer through the use of a sophisticated computer system is essential in the development of an efficient primary care network. I note that in the GHAA December Group Health News that not having this capacity was one of the reasons for Safeco's HMO United Healthcare being shut down.

As revealed by the information system, each medical group's specific performance can be measured. Selected portions of this information are discussed at the monthly meeting of the Advisory Medical Council of Group Health Plan. We feel this has significantly improved the overall performance of the medical groups. Three times during the past five years, contracts for medical groups have not been renewed based on information revealed during the quality monitoring and the subsequent failure of the group to improve the quality of its services. Patients are encouraged to call the Patient Relations Department if there are any problems. All telephone calls regarding medical care problems are handled promptly to ensure patient satisfaction. These calls are logged and each medical group receives a report of any calls from their specific Group Health Plan member.

The total performance of the medical group is evaluated yearly and any problems are reported to the Executive Director, who will discuss them with the director of the medical group. At present, the number of phone calls reporting patient complaints is minimal. All decisions as to the quality of care and necessity of the services are made by the Medical Director in consultation with the Advisory Medical Council. All decisions regarding financial aspects of the medical care are made by the Executive Director in consultation with the Medical Director and with the Medical Council Executive Committee. This has been a satisfactory relationship and, up to now, there have been no significant conflicts between the Executive Director and the Medical Director.

Group Health Plan marketing technique for the Medicaid population is very softsell. This policy is supported by the Ohio Department of Welfare. A letter is sent to prospective Medicaid enrollees signed by the Director of the Ohio Department of Welfare, accompanied by a fact sheet explaining how Group Health Plan of Northeast Ohio works with the Medicaid population, a directory of names, addresses and hospital affiliations of all Group Health Plan physicians, a list of dental and eyeglass providers, and the pharmacies that accept Group Health Plan patients. A prepaid business reply card

provides space to confirm one's interest in receiving more information about Group Health Plan or in joining Group Health Plan. The Ohio Department of Welfare supplies Group Health Plan with mailing labels of all eligible recipients for ADC.

The Public Programs Department of Group Health Plan, responsible for marketing and enrollment, gets back about 10% of the business reply cards indicating they are interested or want to join. When the cards are received, our outreach workers call the prospective enrollees by phone, explain the program and answer questions. If the person wishes to join, information is taken down over the phone. An enrollment application is typed with the information on it and, together with a self-addressed, prepaid envelope, is sent to the applicant for signature.

In-and-out eligibility is a big problem. There are three kinds of in-and-out eligibility: (a) the entire case is closed; (b) individual recipients in a case are terminated; (3) individual recipients are added. The largest county in our service area, Cuyahoga County containing the City of Cleveland, has roughly 130,000 eligible recipients for ADC. With this county we have reached a good arrangement on eligibilities. By the 20th of the month, the county supplies GHP a print-out of case closings for the first of the following month, plus additions and deletions of individual recipients, effective for the first of the following month. With the other counties, we have to pick up case closing and recipient deletion based on their non-payment of the capitation for the particular person. The voluntary disenrollment rate is 5-7% monthly.

The relationship between the State Welfare Department and GHP has been excellent, all concerned being eager to make the plan work. The benefits to both parties are apparent. The patient receives the same quality and type of care as the fee-for-service patient. The physician is reimbursed on the same schedule as the rest of his practice. GHP does not appear to be a welfare-oriented organization, since the welfare patients are distributed in small numbers among many medical groups and are seen in the private offices of physicians practicing in all settings in the community, both in regard to their location and the incomes of their patient population.

The Welfare Department has a predictable cost, somewhat less than the average for the remainder of their clients, and the assurance that their patients have access to quality medical care. The physician can provide service to welfare patients without billing or fee discrimination problems. The advantage to GHP is that its program has brought it an

increased enrollment, and has affirmed the philosophy of the GHP Board, that this plan is for all segments of the community, with a single door policy providing care to the rich, the middle class, near-poor, the poor, and the elderly — all on an equal basis.

Let me give you, from our experience, a few comments about the primary care network and its implication to the delivery of health care for the Medicaid population. One aspect that is very striking in the primary care network is the dramatic reversal of the role of the family physician vis-a-vis specialists and hospitals. I think we all recognize that for many years, the medical care delivery system political structure has been dominated by specialist input. Putting the primary care physician in the role of "gatekeeper" or manager dramatically flips the coin. Another observation concerns the implied or actual threat perceived by hospitals in reacting to the primary care network. Not only is it a challenge to the open ended utilization of the hospital emergency room for primary care but also substantially reduces the number of hospital days needed for an enrolled population, i.e., Medicaid HMO members utilize many lower hospital days per thousand.

The fact that the primary care network uses all or most of the community's hospitals, rather than a single hospital site such as is present in the staff-group model HMO, means that the hospitals not only become a part of the problem but become a part of the solution in the development of an effective primary care network. In the greater Cleveland area, we have seen signs of distress on the part of the hospitals.

For many years in Cleveland, the only discount available in hospital rates, other than Medicare/Medicaid cost settlement, was the discount that all hospitals gave to Blue Cross. This process has resulted in much furor of late. Attorney General William Brown, of the State of Ohio, has filed an action against the Greater Cleveland Hospital Association and Blue Cross of Northeast Ohio, based mainly on a restraint of trade complaint. This matter will probably be before the courts in 1982. At one point, about eighteen months ago, I attempted to institute a cost settlement rate with the hospitals for our Medicaid members' hospital bills; basing this action on the fact that the state was setting our premium according to their Average Adjusted Per Capita Cost (AAPCC) and the fact that these were essentially federal or state Dollars paying the hospital bill. The state AAPCC was based on a lower hospital rate than we were able to obtain. I received data on cost settlement rates for various hospitals and started instituting a reduction of payment based on this historical cost settlement rate. This created a tremendous stir and

resulted in much pressure by the Greater Cleveland Hospital Association against the Ohio Department of Public Welfare and GHP. Because of all the agitation we decided to temporarily discontinue this practice until further clarification by the Healthcare Financing Administration and the Ohio Department of Public Welfare. There is a bill in the Ohio Legislature at this time to equalize all hospital charges. We are not sure how far it will get.

Another observation I might make concerns the Medicaid members' behavior vis-a-vis the primary care network. Of course some of this is subjective but we believe that when a Medicaid eligible joins an HMO, that indelibly printed in his behavior is a sense of discipline in the utilization of appropriate health care service. Once the Medicaid eligible individual has established an HMO attachment and utilizes the services of the HMO, we feel we can change inappropriate behavior significantly. That's why it is such a shame to have the large rate of cancellation for either voluntary or involuntary reasons. I look forward to the application of the new Medicaid regulation that will allow the states to guarantee six month membership to the Medicaid eligible, even though they subsequently lose their Medicaid eligibility. I wonder how many states will implement this provision?

Another area I feel to be very pertinent is the effect on the Medicaid provider (physician or dentist), who is now involved as a contracting provider in the primary care network. The provider that has had extensive Medicaid indemnity experience undergoes a double-think. The new financing mechanism alters the provider behavior in a discreet, but measurable fashion, tilting it towards fewer encounters and reduced use of specialists and hospitals. In addition, local physicians and dentists that had not previously accepted Medicaid patients were now willing to do so. The explanation for this may lay in the fact that a major obstacle that dissuaded them from serving Medicaid indemnity patients in the past was administrative rather than being based on level of reimbursement or the poverty image of the clientele. Many of our providers did not provide care to the Medicaid population until they became contract providers of Group Health Plan. It has long been recognized that there has been a low percentage of the total number of providers in the Medicaid system, as well as a low percentage of utilizers. Perhaps the primary care network can serve to moderate this problem.

Another obvious effect on the providers is the new recognition by them of total cost factors in the delivery of care to the Medicaid population. Under the GHP system, the

primary care physician now sees and pays all specialist bills, lab and x-ray, and is generally aware of all hospital costs for Medicaid patients.

Another area which I believe calls for further examination is the question of the AAPCC. I have discussed this with my friend, John Van Steenwyk, and it is my contention that the formula does not accurately represent the total per member per month indemnity cost for the Medicaid patient. This, of course, presents a burden to the HMO because the HMO is only getting a percentage of the AAPCC for its premium. In conversation I had with the Marshfield Clinic recently concerning their Medicare experimental project, they felt that the Medicare AAPCC for their region was too low and put an undue burden on them, resulting in significant losses.

One of the major factors in the success of the primary care network is adequate information transfer. We are now on tape-to-tape transfer of information with the state and this has proved fairly effective. Misinformation on eligibility and ineligibility can create havoc in a primary care network. Because of the linkages involved between the potential Medicaid HMO member, the local case worker, the county Medicaid system, the state Medicaid system, the HMO administrative arm, the physician and dental primary care provider, the referral provider, the emergency room and the hospital, there is great potential for breakdown. Our major efforts have been involved in building an adequate computerized system and database. We have had excellent cooperation from both the counties and the Ohio Department of Public Welfare and this is essential.

Last, but not least, the state governments, in converting the Medicaid eligible population to primary care network (GHP) models, will face intense political pressure from the existing health care delivery system. We, in the HMO field, have never believed in locked-in populations but favor dual or multiple choice as an essential part of our genetic code. I'm looking forward to the experiment in Arizona which appears to be taking a quantum leap forward in addressing this problem. Governor Babbitt will have his feet to the fire.

Group Health Plan is proposing an arrangement with our State Medicaid Department to take over the care for the entire ADC population in a single county. We will provide to the Medicaid eligible individual a choice between a foundation, in which all the primary care providers can be involved, or the HMO, in which only selected primary care providers are involved. We will manage the entire system. The ADC population in this particular

county is approximately 18,000. We believe that we can provide a total care health care system that will maintain quality at a significantly reduced cost. We have had favorable comment from both the State Medicaid office and the County Medicaid Director. We hope to initiate this process sometime next year.

We realize that we are going to have to have a lot of steel in our spine to resist the opposition from Organized Medicine, which is waving the flag of "freedom of choice". I'm not sure who's freedom this is for, the providers or the beneficiary. We can also expect strong opposition from the local Hospital, Dental, Pharmaceutical, Optometric, Chiropractic and Osteopathic Associations, along with facing the political power of the Boards of the local hospitals. I hope the state and federal governments can back us up strongly enough to proceed with this project. We feel it can serve as a wave of the future for serving large segments of the Medicaid population. It has worked successfully at Redwood Health Foundation in Sonoma and Mendo-Lake Counties in California, under the direction of Dr. John Kenney. Dr. Fred Light, our Medical Director, feels the proposed Group Health Plan model has a broader application since we are utilizing both the fully capitated mechanism and the foundation mechanism side by side.

I want to thank you for your time and attention and I would be glad to answer any questions further down the line.

THE PHYSICIAN – BASED GROUP PLAN OF BALDWIN COUNTY GEORGIA

Frank Evans, M.D.
Vice-President, Middle Georgia Medicalcare

In our current health care system, individual doctors direct most medical expenditures, whereas administrators try to limit costs through persuasion or regulation. This system is predictably wasteful because no one is held clearly accountable. If those responsible for cost control do not interfere with the care of patients, physicians tend to overspend. On the other hand, the quality of medical care is threatened when administrators modify the decisions of physicians. The physicians of Baldwin County, Georgia have created a competitive structure for Medicare eligibles which avoids this defect by unifying the accountability for both the cost and the quality of patient care in the primary care physician. It is called "Physician-Based Group Plan".* In simplified terms, it will operate as follows:

- Each primary care physician submits fee data to the Plan, and the Plan actuarially calculates the monthly premium for each physician based on the predicted medical expenditures of his patients.

- Each person eligible for Medicare selects his primary care physician and pays a monthly premium to the Plan which is specific to the selected physician and which includes a prepayment for deductible costs. Medicare also pays a premium to the Plan which is fixed regardless of the physician selected.

- The primary care physician takes care of his patients' medical problems and authorizes all non-emergency referral care including consultant, hospital, and laboratory services.

- The Plan pays the patients' medical expenses in full as long as they are authorized by the primary care physician.

- Savings produced because a physician pays close attention to costs accrue to his patients rather than to the physician or the Plan.

---

*An article by Dr. Evans in the New England Journal of Medicine which also discussed this plan is reprinted in Appendix II.

Role of the Medicare Eligible

There are about 3,000 elderly people eligible for Medicare who are attended by the primary care physicians of Baldwin County. These eligibles will have the option of continuing their present coverage under Medicare or selecting one of the 15 primary care physicians participating in the Plan as an alternative Medicare option. If the Plan is selected, the patient must agree to obtain all primary care from his physician and any non-emergency care, including specialty, hospital, and laboratory services, only after referral by his physician. Eligibles who self refer for non-emergency care will be required to pay an additional out-of-pocket deductible at the time of service. Except for self-referral, the premium includes prepayment for all deductible costs. Unused deductible payments will be refunded to the patient at the end of the year. Eligibles are free to change their primary care physician in the course of the year or to withdraw from the Plan, which automatically reinstates their traditional Medicare coverage.

The Medicare eligible has the opportunity to gain by the Plan in several ways. First by choosing a less expensive physician, he not only saves money, but he also forces less efficient physicians to pay attention to cost. Second, full payment of all costs in advance wil relieve the anxiety many patients have over the uncertainty of their Medicare coverage. Third, patients will avoid the frustrating task of filing insurance claims. Finally, since the patient pays his premium in advance, there should be little opportunity for disagreement over money between patients and physicians. This should strengthen the relationship between the patient and his physician.

Role of the Physician

Any physician may become a primary care physician if he is willing to take responsibility for a patient's cost of care. The monthly premium the Plan establishes for him will be determined by the cost and frequency of his own charges and referrals, with the greater emphasis on his own charges. Incidences of catastrophic illness are appropriately discounted so that they do not distort his premium. Once a year, the primary care physician sets his own fees. He cannot change these fees in mid year since the Plan guarantees his patients' premium based on the fees he sets. This overall system is actuarially sound because the risk is spread across all participants in the Plan, and monthly premiums are set high enough to insure adequate funding. At the end of the year, any unused premium will be returned to the patients as a cash refund.

Since the premium depends in part on referral costs, the primary care physician will be induced to be aware of cost differences among consulting physicians, laboratories, and even hospitals. Hence, the physician, rather than a non-physician regulator who has little understanding of quality of care issues, will become the evaluator of the appropriateness and cost of medical services.

The primary care physician has a number of incentives to participate in the Plan. First, he may set his own fees. Second, he will be paid a small management fee of $30 per patient per year. Third, payment for his claims will be made using a "sight draft" system whereby he writes himself a check for his services using the Plan's sight draft form. This system results in immediate payment without bad debts or collection expenses. The sight draft form also services as the insurance claim and eliminates the cost of filing insurance. Finally, the Plan depends on competition to control costs and as a result, it is almost free of regulation. For most physicians, these will represent significant advantages.

Discussion

The Plan is structured so that a market is created where each primary care physician competes for patients with traditional Medicare and with every other primary care physician. Each Medicare eligible is free to make a choice based on his own preference of physician or plan. The eligible is encouraged to make this choice wisely since he keeps the savings or bears the extra expense that results from his decision. Likewise, the physicians are encouraged to be good managers since patients can easily compare physicians with each other or with traditional Medicare.

The Plan has strong local support including the formal approval by unanimous vote of the Baldwin County Hospital Medical Staff, the Baldwin County Hospital Authority, and the Baldwin County Board of Commissioners. Every primary care physician in Baldwin County has agreed to participate in the Plan. The Plan is a Medicare demonstration that has been funded and will be fully underwritten by the U.S. Department of Health and Human Services. The Georgia Department of Medical Assistance will participate with support for Medicare patients who are eligible for Medicaid. Finally, the University of North Carolina and Vanderbilt University are planning a rigorous evaluation of the project.

The Plan's development was made possible through a generous grant from the John A. Hartford Foundation of New York. It will be administered locally by Middle Georgia

Medicalcare, Inc., a Georgia non-profit corporation that will be designated an ad hoc Medicare carrier for Baldwin County, Georgia.

Many physicians oppose government financing of health care because they fear arbitrary regimentation and inflexible guidelines for the treatment of patients. This Plan is successful and reproducible and could become an alternative to the regulation of medicine. If it achieves proper physician independence and adequately balances cost against quality, it will have strong appeal to patients, physicians, and political leaders alike.

Questions and Answers

Panel 1

Q **(Russ Schwartz, New York)**

Do any of the PCNs today utilize hospital-based clinics? If they do, what has been their experience?

A **(Bond)**

At Providence Medical Center, (the second largest hospital in Seattle), United Health Care had utilized the Providence Family Medical Clinic, which is a hospital-based clinic. Their cost of care was a little bit higher than the average, but not appreciably out of line.

(Davis)

One of our major providers is a University hospital-based system. Dr. Schmidt and Dr. Abramson will speak on that this afternoon. They represent the University's family residency program. That's a major provider for Group Health Plan's Medicaid and private patients.

(Simenstad)

We have the University of Wisconsin also in the program. Their costs are really high, especially on the hospital side. We try and talk to them, but they're pretty big and the people there who are interested in it--it's hard to communicate down the line. They have got 400 physicians on the staff; it's a little hard to catch their attention.

(Bond)

We also had the university physicians, which was an in-house clinical facility at the university hospital, (which is the medical school), and they killed us!

(Simenstad)

They are the most expensive. We have a variable capitation rate, based on the 27 sites that we operate with, seven big clinics, the university, then some pooled organizations, IPA-type thing, and the university is by far the highest. We have to get a little more aggressive in talking to them. It's hard to manage them.

Q **(Tom Russo, New Jersey)**

We in New Jersey have struggled for many, many months trying to come up with a workable and reasonable definition for distinguishing between true emergency care

delivered in the emergency room and non-emergency care provided in the emergency room. I'm wondering if any of you in your plans or programs have had that difficulty and have been able to come up with any solution. In our estimation, if we can ever come up with a way of defining that difference, we can probably save a lot of money.

A **(Davis)**

Personally, we have this problem daily. I don't think you'll every get a perfect definition. We do relate to the hospitals. Our hospital cost containment effort is the most difficult part in our HMO. We made a little money last year, we're going to make a little money this year. We'd make a hell of a lot more if we had some hospital cost containment. The emergency room is a great big problem. We meet with the emergency room physician, and if it's an emergency room group, to try to help them to define that. We have in fact issued some new documentation on that, but it will continue to be a point of contention. Some of the hospitals claim that everyone that walks into their door--they're going to give treatment to them regardless, and not even find out the source. So if you deal with 45 different hospitals, you're dealing with a lot of different administrators and administrative opinions. We have some definitions we'd be glad to share with you. We think they've been useful. The major definition is to resist and stick to your guns, frankly. That's what we have to do at times. So we do have confrontation involved.

(Simenstad)

We have a list of diagnoses, and we have occassionally denied some, but we haven't been as tough as we should. We have a gigantic plan and there are an awful lot of fires to put out when you've got 182,000 participants.

(Bond)

We've tried to use the life-threathening thing and it just causes argument after argument. This is why we finally just set up--in the private sector obviously--a $50 deductible. If it's an emergency, they're going to pay it. If it isn't, they are probably going to wait.

Q **(Bruce Hansen, Michigan)**

Two questions. You quoted a utilization rate of 425 hospital days per 1,000 population. What specific population are you looking at?

A **(Davis)**

The AFDC population enrolled in our program in Ohio.

Q **(Hansen)**

Second question: Did I hear correctly that you have CRTs (cathode ray tubes) in your primary care physician's offices?

A **(Davis)**

No, the CRTs are in our administrative offices. The information is sent to us in bulk from the various physician provider offices. We enter them into our CRTs and into our system.

Q **(Hansen)**

What specifically do you enter?

A **(Davis)**

Encounter forms: We have a very specific encounter form that's been designed for the provider, both medical and dental. That's a very simple document; takes only a few seconds to fill out. That is batch processed to us and put into our system.

Q **(Hansen)**

How do you handle claims processing?

A **(Davis)**

Claims processing is done manually right now, but we are going to computerized claims processing in the near future. That's a big problem with which I know all of you are involved. We do have extensive claims processing, where we're denying bills and there has to be reconciliation. We have to have approval of billing by the primary care physician if it's a referral physician bill for a hospitalization, and that becomes rather complex. But it is very do-able with the capability of the present information transfer systems.

Q I have a question for Dr. Davis: Is your Medicaid capitation rate subsidized by your other groups?

A **(Davis)**

No, we analyzed that from a cost factor. We had Ernst and Whinney as our auditors, in fact. In 1980 we actually had a higher return for members per month for Medicaid than we did for the general population. Remember, we also serve the near-poor under the 330 grant, and they are the most expensive population to serve. We have a lot of adverse selection there. We've had that since our inception as an HMO. We find that Medicaid utilization is not much different from the utilization by the other parts of our population spectrum.

Q Do you anticipate a shift from fee-for-service to pre-paid practices?

A **(Davis)**

I've debated that with people from Maryland, Pennsylvania, and all over the place. It's very difficult for us as a CHC (Community Health Center) to convert from a primary health care fee-for-service system to a pre-paid. Health Norwood in Cleveland is a primary care health center that was funded on a fee-for-service basis

on a sliding scale. They are part of our network, so part of our membership selects their sites. They've done fairly well on that. We've analyzed their figures--I don't have that data--but they find it to be a very relevant way to bringing more volume into their practice to maintain their funding appropriately. So I think it can be done. I think it's kind of tricky to convert CHCs from the fee-for-service, open-ended techniques they've had in the past.

(Simenstad)

I just want to make a comment, though I know less about Medicaid than Medicare, but I think that the reason our private program works is that the physicians have a large enough segment of business. So when you convert from say a 10 to 15 percent Medicaid business in the providers' practice, I think that would be something that would favor getting the thing going. That's why our program has gone. In Safeco, I'm sure some physicians just had too few patients to really want to do a very good job at it. I would think the conversion would be very good in our state, if you've got a high enough percentage of these indigent patients.

Q **(Bartlett)**

In terms of giving these folks a real sense of what primary care networks are, please explain what are the incentives and economic underpinnings of this concept. Do you see the idea of the physician (the primary care physician) being at financial risk as an essential element of primary care networks?

A **(Ross)**

I think so. I personally did not believe that as United Health Care was going down the tube. I really questioned, as did a lot of other people, as to whether the financial incentives were really there. However, having gone out now and talked to doctors, the doctors tell us that the financial incentive is very important to them. It's not the money; it's a game. It is the way they keep score. And we have found, as I have talked to doctors, that doctors know who among their associates, not in their office but around, who had a deficit, who had a surplus. It's sort of your golf handicap. It's important to them.

(Simenstad)

I would agree. I do a lot of work for Medicare reviewing physician profiles. There are amazing differences in cost per Medicare beneficiary per year for the various specialties, and our problem in Medicare is to get this out to them and say, "you're ranked high, you're ranked low." Now in Medicare we can't kick them out of the program, but we have put a couple of people on fee-for-service and reviewed their claims, each and every one. We took the capitation thing away from them, and manually looked at their claims very tight, and they shaped up.

(Davis)

I believe very firmly in the need for risk. It's been implanted into our system up to the point for the risk for specialty care for the physician. I think that's a very cardinal point which some of the primary care networks are not giving to their primary care provider. They're not giving them the specialty risk. I think that's very important: we have some developing in Ohio now that did not include that in their genetic code and I think they may be doomed to failure. The graphic example of that is what happens with open ended systems is the recent testimony before the House Committee on Federal Employees' Benefits. Blue Cross lost $181 million in 1980, it's projected they are loosing $250 million this year: that's because of the open-ended aspect of the system. I think putting physicians at risk can solve a lot of that. It can even affect the hospital days and hospital costs eventually. I'm a firm advocate of that.

(Evans)

I agree with that. I especially agree with Ross that the major impact is the sort of score keeping business instead of the actual financial impact on doctors. I know when you're down in the emergency room with a patient and you've got the family sitting around and the patient is about to die, you don't add up the medical care cost. It's sort of the average if you have to live with that--that's the important thing. Doctors tend to be sort of an arrogant group and they compare each other. The score-keeping is very important.

Q **(Curtis, NGA)**

I'd like to address my question to Ros Bond. I got the impression from the preconference draft of the Spitz paper that what was probably the major conceptual fault with the original United Healthcare design was the lack of incentive for primary care physicians to restrain the use of specialist services. I now have the impression that perhaps the problem was the plan's inability to weed out high cost providers. Which of those two do you think was the greater problem?

A **(Bond)**

I think the second. That's the one part of Bruce's paper that I don't agree with. It's a neat excuse. I've just a read a similar statement in the Group Health News to that affect, and to me that's a cop-out. We very definitely came to the conclusion that you had to be careful in selecting primary care doctors. In our new network, we are signing up only pediatricians, family practice, general practice, and we are very selective when it comes to internists.

Q **(Hansen)**

Is it fallacious to assume that a primary care physician can control a specialist?

Secondly, what have you all done to look at the price of hospital costs? I beleive that the network that we discussed today will get at utilization, or potentially get at utilization, but on the cost side, what initiatives have you taken to reduce that particular aspect of hospital costs?

A **(Simenstad)**

When I was in North Carolina a year in a half ago, they were touting Safeco, and I said it won't work. I think they thought I was just not talking straight. For that reason I don't think primary care people can get tough enough with specialists, unless there's some help, some type of feed-back from the company almost on a monthly basis. I would agree wholeheartedly.

Q What if the primary care physician writes the check?

A **(Simenstad)**

He still won't do it. It's too uncomfortable. I thought at that time it wouldn't work, and I wasn't too surprised.

As far as the hospital cost issue, I think the hospitals have to be encouraged as a group to do something like the Rochester, NY plan. I'm on a task force now at the Wisconsin Hospital Association. Rate review is down the drain in our state. We're trying to set up some type of cost-effectiveness corporation of which each hospital in the state will be a member, and there will be feedback, comparing hospitals. Just like Frank talked about comparing doctors. We have to profile hospitals and we have to get disclosure out and exposure. If we can do that, the doctors will correct themselves and the hospitals will correct themselves. I hope that this program will work, but that's the avenue. I don't think an insurance carrier will do it. One of the people on our task force used to be from the Department of Natural Resources and worked on industrial pollution of streams. He pointed out that you have to go and talk to the industry. And the same thing here: you have to go and talk to the hospitals as a group. You can't come at them from on high, from some office in Madison or Lansing. You can't do it. You deal with doctors out there and you deal with hospitals out there. The hospitals are starting to do this.

(Davis)

We had a consortium at the greater Cleveland Hospitals Association, one of the oldest hospitals associations in the country, which was really somewhat in restraint of trade, as I mentioned. We have sort of picked off hospitals one at a time, going to them and asking them for a rate based on their cost formula, with either the Medicaid patient or with Blue Cross. We have five hospitals now that have given us either a flat rate or a reduced rate. We think that we can go after them one at a time because they are threatened with survival. My daughter happens to be a

hospitals administrator in New Jersey and we discussed the effect of the DRG program there. Our feeling in the Cleveland area is that many hospitals will go under as predicted. With the kind of systems with the primary care network, they are definately threatened. But I think it's appropriate, frankly. I believe we can have an affect on hospital rates very directly, and I do believe our physicians find paying the specialist directly does have an affect. They do not seem to mind doing that. I think that Dr. Schmidt may speak to that point this afternoon. So we do have different experiences in different areas. It's possible the climate is different in each state.

(Evans)

We're in the process in Baldwin County Hospital of trying to decide whether to purchase a CAT scanner. What's happening is that the radiologists are in favor of purchasing the CAT scanner, for obvious reasons. The medical staff is sort of neutral on the CAT scanner, because after all they don't pay for the CAT scanner--the patients do. And you can keep patients in the hospital in Baldwin County and work them up if we have a CAT scanner there. I've had many discussions with the hospital administrator. He doesn't know whether we need a CAT scanner or not. You can force hospitals to lower their cost in one way or another, and if you do, you'll eat into their reserves or make them get the costs from somewhere else. If you really want to cut hospital costs in a realistic sense, somehow or another you've got to get the doctors to decide that it's better not to have a CAT scanner and to make the choice the other way. The hospital administrators can't do it.

Q **(Gretchen Enquist, Missouri)**

My question is a conceptual one concerning these primary care networks. Do you really need them? Are you really changing physician practice patterns? If a state is able to share risk and to develop a good enough selection mechanism to exclude the high cost providers, do you really need anything else?

A **(Simenstad)**

When I thought about coming here, I was a little bit worried because several things have killed us: inflation, and technology, and access. We have just got too much access in the system. In our state anybody can jump into an ambulance because we have EMTs and sail into the hospital. We've corrected our problem of a two-tiered medical society by providing an awful lot of access. I have worried about the primary care network being just too available. I think we have to watch the access. That's what killed us. If you put a doctor on every corner, you're going to have a lot of access, even though you try and be selective. I don't know how far you have to go

to get to one of Dr. Davis' clinics in Ohio, but if you have to go ten miles that might help. Maybe you want to say something about that.

(Bond)

I agree with that. This is one of the reasons we are cutting our primary care numbers of doctors down. From a marketing standpoint I originally thought the more doctors we had on the list, the better off we are. I was wrong beause it created access and it made it very easy for people just to say, "Oh, yeah, there's my doctor, I'll join this plan. It's paid in full, etc." I've changed my mind. The fewer doctors you have, the better off you're going to be. To specifically respond to your philosophical question as to whether you need the network, I think an essential ingredient is selecting cost effective doctors. But they are like anybody else--once they're selected and participate, they need to be fed and informed and they need to be drawn into this thing and reinforce one another. I think that's where you need the primary care network.

Q **(Paul Allen, Michigan)**

Have you observed that a small subset of your public sector population uses most of the hospital care. I think there have been several studies which show that 13% of the patients use about 50% of the dollar in the hospital setting. You also mentioned the problem with alcoholism and psychiatric care. I'd like to know: on the public side, have you observed any way to control this?

A **(Bond)**

We don't have any experience on the public side but we very definitely can indicate that about 15-20% of the people use most of the care. Unfortunately, out of the last phase of a study that's just coming out of the University of Washington, apparently that's a shifting 20%. A very large portion of care is elective. We go through a natural curve of heavy intensive use of medical care and we slide into less intensive use and we sort of enjoy our good health, and then we go into another curve. People instinctly know that, and we have seen anti-selection. There is anti-selection, but it's a shifting 20. And I bet you you have the same thing in your own population, in the public population.

Q **(Bartlett)**

A general question to each of the speakers. Each of you have been very good in describing how your plan is set up, how it has been operating, how it intends to operate. Do, if you would, one of two things. Either put yourself in the position of a Medicaid administrator, someone who is dealing with this issue in terms of a go/no go decision, or if that's too uncomfortable, put yourself in the position of sitting

down across the table and talking with one of these folks about the idea of whether or not to go with the primary care network in their states. Tick off some of the things from your experience, primarily in the private sector, that you would look out for, that you suggest they look out for--any set of suggestions, observations, etc.

A **(Bond)**

I'd do two things. I would pick a relatively small area to try it in. Secondly, I would not try and create the perfect plan. I have a plaque over my desk--I look at it every day. It says, "A perfect plan is a mortal enemy of a good plan." Don't nitpick it to death, trying to make it perfect. Put it into operation. In sharing risks with doctors, you are going to have to take some risk if you are ever going to find out what works and what doesn't. Keeping it small minimizes risk but you will find out one heck of a lot.

(Davis)

I would select small samples also. We went into this Medicaid situation about four years ago with the State of Ohio. I don't think either side was rather knowledgeable about what would happen. We found it a very good experience--it worked well. The question now, for Group Health Plan is, "Is it clonable?" The GHP is now part of a national HMO system called Health Plans out of Nashville. They are very interested in our system, it is one of the reasons they came in with us when we merged with them. They want to see if we can take this model and utilize it in other states for publicly and non-publicly funded patients. We see it working in our community. We think the model can be applicable in other areas. We don't know whether you can get the cooperation you need from the medical community. One point that I wanted to make earlier: when you talk about selecting good primary care physicians, that's only one side of the coin. Sometimes that primary care physician is not interested in working with you. We had rather intense resistance from the medical community when we first started out. It took a long time before we were accepted. So to just say that you can set this up automatically is impossible. You have to have the right characters in place. You have to have the medical providers, you have to have the dental providers, good administrative apparatus and good systems. I think it can be done. It really is a wave of the future. We are going to find that PCNs could be an answer to providing quality care at a lower cost. And I don't just mouth that--it can be done. It may take a long time, but there's a lot of history out there in the woodwork, and if you bring that together you can do some very interesting processes in your states.

(Simenstad)

(1) Push primary care, (2) Keep the physician informed--data, data, data--on a regular basis so they are always aware of what their decisions are doing, and (3) Alternatives is the name of the game. If you don't hospitalize, take care of them in an out-patient. If you don't put them in a nursing home, get community support services to take care of them. Don't do elective surgery, etc. It's the alternatives: why give everybody a wheelchair when they can get crutches? That's what we've done--Alternatives! The physicians know that but they haven't had to face up to it.

(Evans)

Talk to the doctors and the hospital administrators when you start introducing something because frequently they can give you a point of view that's a little different.

PANEL TWO

THE EXPERIENCE OF PRIMARY CARE NETWORKS SERVING AN INDIGENT POPULATION

Included in this section are the presentations by the following representatives of organizations which have set up primary care network/case management systems to provide care to Medicaid and/or non-Medicaid indigent populations.

Group Health of Northeast Ohio

David Schmidt, M.D.
Director, Department of Family Medicine
University Hospitals of Cleveland

and

John Abramson, M.D.
Department of Family Medicine
University Hospitals of Cleveland

Multicare of Multnomah County, Oregon

Becky Belangy
Director, Project Health
Multnomah County, Oregon

Massachusetts Medicaid Case Management Program

Dennis Beatrice
Assistant Commissioner for Medical Services
Massachusetts Department of Public Welfare

GROUP HEALTH PLAN OF NORTHEAST OHIO

David Schmidt, M.D.
Director, Department of Family Medicine
University Hospitals of Cleveland

I would like to return to some issues raised this morning. Physicians and Medicaid directors have to become allies in this battle against cost containment.

The only way that this can be accomplished is if we both share the financial risk. If you try to solve this problem with regulations, you're going to lose. I've been around for a long time at many kinds of providers sites, and I've seen a lot of regulations come down the pike. I've beaten you on every single one of those. So we've got to become partners. The only way that is going to be done is if we do share the financial risk.

I can't speak for all of primary care, but I can certainly speak for family medicine. You do have potentially great allies in the family medicine--physicians.

Someone said that the primary care physician cannot control specialists. I can not accept that. When I write the check for services, I have ultimate control. And not until I got into the insurance brokerage business did I realize what rip-offs do occur in the community. As an example, a community surgeon--not at the University--sent me a bill for $1,700 for half an hour's work for sewing up a tendon in the emergency room. I asked some national figures on our campus what the procedure was worth. They gave me a rough ball-park figure, and I sent the surgeon $800 and I told him to sue me. Of course, he didn't. But I had no idea that this type of billing was going on when Medicaid or Blue Cross was paying the bills. The physicians have got to get into the act.

Earlier, Dr. Davis described the Group Health Plan. Dr. Abramson and I are going to share with you our experience as an individual provider group with this plan. We have had a contract with them for approximately 30 months. Let me tell you something about our practice. It is a private practice. It is a University-based practice. It is the teaching program for a family practice residency program. It mixes all types of patients. On a given day, I will see the president of the University and I will also care for someone from the inner city. They sit side-by-side in the waiting room.

We thought long and hard before signing up with GHP. At first glance there are a number of feature of our practice that would put us a high-financial risk. You all are aware that the type of care provided in a university setting is very aggressive. It relies heavily on technology. In addition to that, the ancillary costs at a university setting are extremely high. Another factor is that the bulk of the care is provided by residents in training. These young physicians rely heavily on laboratory technology and on consultation as they are developing their clinical competence. But there are a number of compelling reasons why family medicine as a discipline should jump in and try out alternative financing schemes.

The long-term viability of primary care and family medicine, I think, is jeopardized by the continued trend for third parties to favor the specialists and their expensive procedures. For example, I receive more compensation from the Ohio Medicaid for reading an EKG which takes one or two minutes, than I do for doing a very comprehensive history and physician exam for a patient who has many problems and a lot of psycho-social problems that are intertwined with medical complaints. So under the current system, there is going to be a low threshold for doing electrocardiograms.

It has already been mentioned here today that an important function of the primary care physician is to coordinate the care of his patients. When I have decided to make a referral, I spend some time gathering together the history as I've seen this patient's problem evolve over a period of time, I get together the lab tests and the x-rays so that the consultant does not have to needlessly duplicate this material. Frequently, after the patient is seen by the consultant, the patient returns to me and I have to interpret what the consultant said, so the patient can make a meaningful judgement about his future care. No one pays for this management function under current reimbursement patterns.

It was Dr. Harvey Estes, chairman of the Department of Family Medicine at Duke University, who first suggested that the capitation-type HMO has the potential of redistributing some of the health care dollar to the primary care physician. That's why we finally elected to sign a contract with Group Health Plan of Northeast Ohio (GHP).

Our practice turns out to be a unique laboratory. We have somewhere in excess of 6,000-7,000 patients with about 20,000 visits per year. This represents a nice mix of private-pay patients from the affluent suburbs, AFDC fee-for-service recipients from the inner city, and the GHP patients which also contain a large percentage of AFDC transfers.

What we are going to do now is share with you some of the utilization and cost data that we have gathered. John Abramson is an old friend and graduate of our training program and is currently a research scholar. He did most of the leg work for this study and he is going to present the data.

FINANCIAL AND UTILIZATION DATA FROM THE EXPERIENCE OF THE GROUP HEALTH PLAN OF NORTHEAST OHIO

John Abramson, M.D.
Department of Family Medicine
University Hospitals of Cleveland

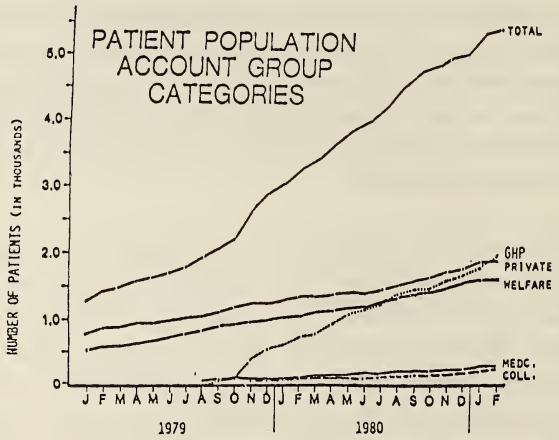
I am going to describe our practice and the effect of accepting Group Health Plan (GHP) patients from a medical practitioner's point of view. I will then briefly present the results of a study comparing the utilization rates of fee-for-service (FFS) and prepaid Group Health Plan of Northeast Ohio (GHP) patients in our practice. Finally, I'll conclude by discussing our findings, and exploring the potential policy implications in terms of paying for the medical care of AFC patients. I'd like to address that issue both from your point of view as state Medicaid administrators in a time when federal support to Medicaid is decreasing and from our point of view as primary care physicians who want to provide care to this population which needs our services, but who also need to make sure that our practice remains economically viable.

Briefly, I shall recap the way GHP works in our practice. We receive a capitation payment monthly for each GHP patient who is enrolled in our practice. In 1980, that capitation payment was $10.35/month, and currently is $11.50/month. Out of the capitation payments, we are responsible for the total range of primary care services provided in our office: doctor, nurse, nutritionist, social worker, therapist, our own laboratory, electrocardiogram, etc. We are also responsible for 100% of consultation fees from other physicians, as well as 100% of the outpatients laboratory and X-ray fees that are incurred on the GHP patients. We literally write the check to pay the specialists, giving us leverage both in terms of patient management and communication with our consultants.

The liability that we have for these bills places us mandatorily in a gatekeeper role. All services covered by GHP must have our prior authorization. This has the tremendous advantage of stopping inappropriate patient-initiated health care utilization. Many other prepaid programs have less direct mechanisms of reimbursement for non-primary care physician services. This compromises their ability to control non-emergency use of emergency rooms as well as self-initiated specialist visits. For GHP patients who do require ongoing specialty care, we remain actively involved in management decisions

because of our direct financial responsibility. In effect, the specialists are working for us, not for the state and not for a private insurance company.

Figure 1 describes our practice by patient population account group categories. Our total patient population at the end of 1980 was about 5,000 people. Thirty-one percent of these were GHP members, 33% were private FFS patients, and 28% were Medicaid FFS patients. Of the GHP patients, 70% were private (receiving insurance through their place of employment, union, or individual policies), and 30% were from AFDC (paid for by the State of Ohio). The GHP population was the most rapidly growing segment of our practice, and this trend has continued at approximately the same rate through the present.



Next, Table 1 shows the overall accounting data for our first 18 months of significant involvement with GHP. From 1/1/80 to 6/30/81, we received total capitation payments of almost $235,000 from GHP. Out of this, we were financially responsible for $108,000 in consultant, laboratory, and X-ray fees. We thus received a net income of $127,000 in capitation payments. During this period, we delivered $114,000 worth of services (at FFS rates) to GHP patients. Therefore, we were reimbursed for services provided to our GHP patients at a rate of 111% of our regular FFS charges. We undertook the following study comparing utilization rates of FFS and GHP patients in order to determine where that 111% came from: Do we have barriers to access to our program? Are we prejudicially delivering care to some patients and not others?

TABLE 1

NET INCOME ON GROUP HEALTH PLAN PATIENTS
1/1/80-6/30/81

Total Capitation Payments Received	$ 234,998
Total Out of Pocket Expense	-107,757
Net Capitation Received	$ 127,241

$$\frac{\text{Net Income (\$127,241)}}{\text{Services Provided (\$114,191)}} = 111.4\%$$

Primary Care Physician and Ancillary Service Utilization Rates

In order to do this study, we drew a random sample of 318 patients who joined our practice during the calendar year of 1980. From this sample we found that the frequency of non-utilization of medical services by GHP patients enrolled in our practice (16% and 20% for the private and AFDC GHP members respectively), is similar to that of GHP as a whole, and probably simply reflects the percentage of people not requiring medical care during the study period.

To examine utilization rates, we first had to define days at risk for patients in the two different payment plans. For FFS patients, obviously the number of days at risk was the total number of days enrolled in our practice in 1980, starting with their first visit. For the prepaid patients, we took the active days in the practice for those who utilized our services, starting not when they enrolled in our program (when we started receiving capitation fees), but when they made their first visit to receive some form of medical care. We included the GHP patients who did not utilize any medical services during the period in question in the study to avoid overestimating the GHP members' utilization rates. This was accomplished by subtracting the average number of inactive days before new GHP patients begin utilizing services (94) from the total number of days the non-utilizers were enrolled in our practice during 1980.

The sample as a whole had an average of 1.46 primary care physician visits per 100 days at risk. Both private and AFDC FFS patients were very close to the mean. The GHP

patients as a whole averaged 1.48 visits per 100 days, though the AFDC patients within that group did have a slightly, but not statistically significant, higher rate of physician visits. The utilization rates of primary care physician visits in our practice was thus concluded to be the same for our FFS and prepaid patients.

The number of ancillary service (nutritionist and social worker-therapist) visits to our practice per 100 days at risk was also calculated. The mean for the sample as a whole was .082 visits per 100 days. The means for the FFS and GHP groups are almost identical, the differences between the individual groups not being statistically significant. We felt it was important to determine ancillary service utilization rates because our practice realizes an income when we refer our FFS patients to our own ancillary services, but we realize no such income when we refer our GHP patients for these services. The findings show clearly that these services were not withheld from our GHP patients.

Total Charges Incurred by GHP Patients

Total charges were defined as all the charges for which our practice was directly responsible: the sum of all charges incurred within the context of our practice, all consultant, outpatient laboratory, and X-ray charges. Table 2 shows the mean charges for the GHP patients as a whole was $39.88/100 days. The AFDC-GHP patients incurred $3.77/100 days less in charges than the private GHP patients. This non-statistically significant difference is due in part to the younger mean age of the ADC group (14 vs 24 years of age for the private GHP patients) and the positive correlation (r = .207 p less than .05) between age and total charges.

TABLE 2

TOTAL CHARGES INCURRED BY GROUP HEALTH PLAN PATIENTS PER 100 DAYS

	AFDC	Private	Total
Charges	$37.67	$41.44	$39.88
Number	46	65	111

Note: Capitation rate = $33.93 per 100 days

It is important to note that, although the mean total charge was $39.88/100 days, the capitation fee received during the same period was only $33.99. The most important factor contributing to the discrepancy between the apparent loss described above and the overall accounting figures which show our practice getting reimbursed for services delivered to GHP patients at a rate greater than our FFS charges is the way that "days at risk" was defined. The inactive period between enrollment in our practice and utilization of medical services averaged 94 days for the GHP patients, and this inactive period was not included in the days at risk. This inactive period provides, in essence, a one-time bonus to our practice. The relative importance of this one-time bonus on our overall income is determined by the proportion of new GHP patients in our practice at any given time.

The number of GHP patients in our practice is currently growing at a linear rate, i.e., there is a fairly constant number of new GHP patients entering. The proportion of new GHP patients, however, is therefore decreasing. The relative importance of the one-time bonus is thus decreasing, diminishing the apparent rate of remuneration for services provided. In fact, after the first 12 months of experience with a significant number of GHP patients, net capitation monies equalled 130% of what our FFS charges would have been for services provided. When we updated these figures to include the subsequent 6 months, this figure decreased to 111%. We expect that a certain amount of patient turnover will continue to provide this bonus effect even when the total number of GHP in our practice stabilizes.

Another important consideration when evaluating the economic impact of GHP on our practice is that our actual collection rate for private FFS patients is 88%. Although this collection rate appears low, this patient group is composed of many working poor as well as middle and upper class patients. Our practice is reimbursed by Medicaid at a rate which averages 77.5% of our FFS charges.

Discussion

The original goal of Medicaid was to provide mainstream medical care to the poor. Sloan, Cromwell and Mitchell in their extensive study of physician participation in publicly funded medical programs[1] examined the failure of Medicaid to have a significant

[1] Sloan F. Cromwell J., Mitchell J. Private Physicians and Public Programs, Lexington Books, D.C. Heath and Company, Lexington, Massachusetts, 1978.

impact on the de facto two class system of health care delivery in our country. On the basis of their findings, they recommend five policy changes, shown in Table 3, which would increase private physicians' willingness to care for Medicaid patients.

TABLE 3

POLICY CHANGES LIKELY TO INCREASE PRIVATE PHYSICIAN PARTICIPATION IN PUBLIC WELFARE PROGRAMS

1. Raising fee schdules
2. Reducing payment delays
3. Simplifying data requirements for reimbursement
4. Increasing the number of Family Practitioners
5. Controlling hospital costs

Source: Sloan et al., Private Physicians and Public Programs, 1978

Sloan et al showed that physicians make practice management decisions largely on the basis of economic considerations, not on the basis of political predispositions. The rate of remunerations from Medicaid patients relative to the rate for other potential patients will determine the physicians' willingness to care for Medicaid patients. Our experience to date is that the AFDC patient enrolled in GHP is more economically attractive to our practice than the private FFS patients (over 111% vs. 88% of FFS charges actually collected). The AFDC-FFS patient is, however, less economically attractive than the private FFS patient (77.5% vs. 88% of FFS charges).

The prepayment mechanism of GHP provides the private physician with capitation payments on or shortly after the first of each month to cover services to be rendered during that month. The long delays in reimbursement from Medicaid has been completely eliminated. Similarly the problem of filling cut, coding and refiling rejected forms has been obviated. The only administrative activity necessary in caring for AFDC-GHP patients is verifying eligibility and paying the bills for services rendered outside our practice.

Family physicians have been shown to be more willing to care for Medicaid patients. The training of family physicians is specifically designed to maximize expertise in the broad range of clinical skills required in primary care. These "horizontal" clinical skills allow the family physician to provide the most complete and efficient medical care to prepaid patients. Group Health Plan of Northeast Ohio, recognizing this efficiency, relies almost exclusively on family physicians to deliver primary medical care. Historically, third party FFS reimbursement policies have been strongly prejudiced against primary care.[2] High fee schedules for procedure oriented and specialty medicine (when primary care physicians are at least as competent to treat the "ordinary" case) have created a situation in which medical students are motivated by financial and prestige considerations to avoid a career in primary care. In a GHP type program, the more equitable reimbursement rate for the time, effort, and responsibility required of the primary care physician as well as the enhanced role as manager and coordinator of the sick patient's care make Family Medicine/Primary Care a more attractive (and potentially more popular) career choice.

The difference in days of hospitalization between FFS-and GHP-AFDC recipients is one of the most compelling findings in favor of the prepaid plan. Studying traditional HMO's, Luft has shown that prepaid health care plans generate about 30% less inpatient hospital days than FFS plans covering similar patients.[3] Our findings are consistent with this trend. AFDC recipients on the traditional FFS payment plan have 1077 inpatient days/1000 recipients/year for the State of Ohio as a whole.[4] AFDC recipients enrolled in GHP average 425 inpatient days/1000 recipients/year.[5] This difference, generalized to the 600,000 AFDC recipients in Ohio at $300/day for inpatient care (a conservative estimate), could represent a savings of almost $120 million a year in Ohio alone.

Conclusions

GHP creates a structure of incentives in which the private physicians' economic interests coincide with those of the state. Because the physician has 100% direct

---

[2]Delbanco TL, Meyers KC, Segal EA: "Paying the Physician's Fee: Blue Shield and the Reasonable Charge." New England Journal of Medicine 301:1314-1320, 1979.

[3]Luft, HS: "How do Health-Maintenance Organizations Achieve Their 'Savings'?," New England Journal of Medicine 298:1336-1343, 1978.

[4]Ohio Department of Public Welfare, private communication. November 1981.

[5]Group Health Plan of Northeast Ohio, private communication. November 1980.

financial responsibility for consultant and outpatient diagnostic studies, as well as partial risk sharing for excess hospitalization, he must consider concurrently the economic and medical consequences of each patient care decision. Quality of care (rates of health maintenance procedures, diagnostic studies, consultations, and hospitalization) must be closely monitored by an M.D. Medical Director to ensure that savings are not realized at the expense of quality.

Our experience to date suggests that a primary care network such as Group Health Plan of Northeast Ohio provides a mechanism for inducing private physicians to voluntarily accept AFDC patients; to provide this care in their private offices, eliminating the indignities and inefficiencies of the outpatient clinic; and to enlist the efforts of the private physicians to deliver this care in a way that minimizes the cost to the state. We are currently engaged in a study to determine the extent to which these findings, both inpatient and outpatient, are due to preselection factors, and to what extent they are actually due to the hanged structure of economic incentives. Finally, the data upon which these conclusions are based cannot be extrapoliated beyond 18 months experience. We feel confident that the basic findings won't change significantly when our practice population stabilizes; however, this needs to be carefully documented before we could recommend large scale policy changes.

MULTICARE OF MULTNOMAH COUNTY, OREGON

Becky E. Belangy
Director, Project Health Division
Department of Human Services
Multnomah County, Oregon

Good afternoon. It is a pleasure to be here and to have the opportunity to participate in one of the first nationwide conferences on primary care networks. I am also pleased that the National Governors' Association has taken the new federalism seriously by including the local government perspective in this meeting.

Today, I'd like to briefly share with you our experience with Project Health, as well as the significant findings of our recently completed five year Medically Needy Demonstration and finally, and most importantly, how this experience has led to the development of Multnomah County's primary care system known as Multicare.

Multnomah County, which encompasses the City of Portland, is the metropolitan area of Oregon. The county population of 559,000 represents approximately 22% of the statewide population. However, like most urban counties across the nation, 29% of the welfare population and 24% of the state's elderly population reside in our community. Although Oregon counties do not participate directly in the State Medicaid program, we do indirectly as a service provider of public health and mental health programs. From 1922 through 1973, we operated a large county hospital, which served not only county residents, but the poor from neighboring communities as well.

The facility by the early 1970's, however, was both a fiscal and social albatross. It was at this juncture that Multnomah County departed from tradition and began to purchase health care from the private sector. The hospital facilities were transferred to the State of Oregon and became part of the University of Oregon Medical School. County general funds were diverted from the hospital and used to contract for health care with community hospitals and providers.

Today, Project Health has evolved as the program which negotiates and manages contracts, processes the claims, determines eligibility and enrolls clients in one of four health plans. The manner in which we contract for services also represents the

conceptual nature of Project Health as well as a working laboratory for the principles of consumer choice and fair marketplace competition. Our clients are the medically indigent or non-Medicaid eligible residents in Multnomah County. Project Health eligibility is based on residency and federal proverty guidelines. Over the past five years we have enrolled the medically needy population under an 1115 waiver-only demonstration project with HCFA. The demonstration ended on June 30, 1981, and the population returned to medically indigent status.

Project Health currently contracts with four health plans and it is in this sense that we act as a "broker" of health care for the medically indigent population. The plans must provide comparable benefit packages which are comprehensive in scope. Nominal co-payments for specific services, such as prescriptions, are allowed. The client selects the plan of their choice and shares in the cost of the premium based on their income level, family size and plan selected.

Prior to this year, Project Health also offered an episodic care program for the indigent not enrolled in a health plan. The episodic program was eliminated due to the extremely high cost and inefficient nature of this "credit-card" health care arrangement.

What then have we learned from Project Health in the past six years, and how has this experience led to the development of our own primary care/case-management system known as Multicare? We found the health care broker concept was successful in negotiating contracts, counseling enrollees on the plans and benefits available, and in removing some of the high risk clients from prepaid coverage through the use of the episodic program. Secondly, we found the Project Health Medically Needy Demonstration cost less than conventional medically needy programs in the States of Washington and California. We also found that indigent clients were willing and able to nominally share in the cost of the premium. Interestingly, the clients' established relationship with their physician, not the cost of the plan, was most often cited as the reason for selecting one plan over another.

Finally, and most significantly, the final evaluation of the Medically Needy Demonstration confirmed that adverse selection is a major problem in integrating the medically indigent in prepaid plans. Biased selection occurs when a portion of the membership of a health plan has either a higher or lower level of health care utilization than the general population eligible to join the plan. We found that individuals and

families in immediate and extensive need of health care were most likely to enroll in Project Health and tended to have much higher utilization rates. This phenomenon of adverse selection resulted in high-risk clients enrolling in the high cost open-panel plan whereas the low risk or healthy population tended to enroll in the lower cost, closed-panel HMO. The health plans solution to this problem has been to raise the premium rate and/or terminate the contract.

This experience, therefore, led us to look for other solutions. We explored how we could provide a "safety net" of health care for the poor without returning to a permanent and segregated system of health care. How could we take advantage of our positive experience with prospective risk contracting? How could we establish a safety valve or risk buffer that would make it feasible to plans to enroll our clients? How could we establish utilization data necessary for a new rate-setting methodology that would go beyond the usual actuarial adjustments of age and sex?

The solution, we believe, lies in the use of a health status appraisal to identify clients' health care needs and the development of the county's primary care/case-management system known as Multicare. The health status appraisal is used as the bridge between the direct case management system of Multicare and private health plans contracted through Project Health. Thus, the appraisal represents the window through which publicly-funded beneficiaries must pass, before enrollment in private health plans. Multicare, on the other hand, represents the management of health care for clients unable to pass through the window.

The health screener is designed to meet three major objectives:

1. To identify persons <u>with</u> immediate health care needs, so that they can be placed in a case management system. The case management system is operated by the county's Community Health Services Division, using county clinics as primary care sites and contracts with community hospitals and specialists for secondary and tertiary care.

2. To identify persons <u>without</u> immediate health care needs, so that they can be offered a choice among the prepaid health plans with which Project Health contracts.

3. To collect data that can be used to quantify the degree of biased selection among the prepaid health plans (that is, the extent to which some plans obtain from Project Health less healthy enrollees than others obtain); and to use these data in conjunction with the health screener to adjust the capitation rates accordingly.

The health status appraisal is administered in a non-medical setting after eligibility has been determined by an enrollment counselor. If the client is not in immediate need of care and has "passed" the appraisal, they have the choice of selecting one of the four health plans. If they have immediate health care needs, they are enrolled in Multicare for a six month period. After this initial enrollment period, their health status is reassessed for enrollment in a prepaid health plan, or they also have the option to continue enrollment in the Multicare system.

The Multicare system formally links the county-operated health care clinics with privately provided specialty and inpatient care in the community. Through this system of care, the county clinics provide for the primary and preventive health care needs of the Multicare enrollees. Our health professionals work closely with the community's health providers through a broad-based contractual referral network.

Multicare became operational on July 1, 1981 and is expected to enroll approximately 3,000 indigent clients this first year. It is funded by county general funds derived principally from property tax revenues and from community health center funds provided by the Public Health Service.

As the case manager, our primary care physicians teamed with other health professionals in the primary care clinic, are responsible for the total management of the clients' health care. This includes:

1. Assessment of immediate long term care needs of the Multicare enrollees.

2. Authorization of referrals, as required, to meet enrollee health needs.

3. Approval of referral billings from community providers after care is delivered.

4. Assessment of the quality of care rendered by community providers.

The Multicare benefit package is comparable to the benefit package provided by the four health plans offered through Project Health. It includes authorized inpatient services, as well as laboratory tests, eye care, prescriptions, ambulance, home health care, skilled nursing, psychiatric, and dental care. All services other than routine and follow-up visits to the county health clinics must be approved by the physician or dentist to be covered under Multicare.

After hours emergency number for Multicare enrollees is staffed by a mid-level practitioner with physician consultation available. The first two months of this arrangement showed 34% of the calls were treated symptomatically and advised to call if further treatment was needed; 33% were advised to seek a clinic visit within two days; 21% were referred to emergency rooms and 12% referred to a physician. Multicare does not pay the bill if a member uses a hospital emergency room or private physician without prior approval from a county clinic provider. Payments for emergency services in life threatening situations are of course, made on an individual basis.

The former Project Health episodic program, which Multicare has now replaced, contracted with a broad spectrum of community providers. All of the community hospitals in the county, nearly 80 pharmacies and more than 1,200 physicians, participated in the program. Multicare, on the contrary, as an organized delivery system will function most effectively with a small group of referral providers who are committed to cost-effective, high-quality care. This spring we will be developing new contracts with providers who are willing to cooperate with the Multicare referral system and our cost-containment objectives. The new contracts will necessitate a review of quality assurance standards as well as a commitment to cost-containment criteria such as the use of generic drugs, outpatient tests, etc. We will continue to work closely with community providers in establishing the contract criteria for physicians and hospitals.

The major problems we have encountered to date are all tied to the lack of data. We are in the process of developing a management information system that will provide us with both the financial and utilization information we so desperately need. A year from now, I hope we can share with you the figures and trending information necessary to evaluate the Multicare system.

Multicare has now been operational for five months, and although there are a number of operational dilemmas, we are becoming more and more convinced of its

potential as a managed system of care. We believe Multicare will allow us to confront the problem of adverse selection in prepaid plans and may well serve as the essential window to integrate high risk publicly-funded beneficiaries into a voucher type of system. For Multnomah County, Multicare at this juncture is not a panacea, but an important integration strategy for fair marketplace competition. That is not to say that the primary care network model is not extremely valid in and by itself, particularly if you can enroll a healthy employed population as well as the indigent or Medicaid eligible client.

Let me close by saying we did not start out to build a primary care network. In fact, for the first several months, we referred to Multicare as "a la Safeco". Multicare has evolved from the operational and fiscal realities facing Multnomah County, Oregon in serving the medically indigent. We have built on the resources we have had available... that is, the county's clinic system and the community's private providers. Our experience with Project Health and the lessons of the medically needy demonstration have provided us with the conceptual direction for Multicare.

MASSACHUSETTS MEDICAID
CASE MANAGEMENT PROGRAM

Dennis Beatrice
Assistant Commissioner for Medical Services
Massachusetts Department of Public Welfare

No one in this room needs to be told that health care costs are rising at an alarming rate and that a major result of this increase is insupportable growth in state Medicaid programs. We have all pursued endless savings initiatives, involving all aspects of our programs, seeking to at least slow Mediciad budget growth. The state Medicaid budget problems we face are symptomatic of national trends.

This year, the nation's medical bill will be $278 billion, up from $75 billion in 1970, an increase of over 350%. Health care has become one of the largest and fastest-growing industries in the United States, accounting for roughly $1 of every $10 spent in this country. If present trends continue, experts say, spending on health care will top $821 billion by the end of the decade.

Increases of this magnitude are simply not supportable to the economy as a whole as fiscal limitations become more acute. Public budgets are already strained to the breaking point under the weight of ever-increasing costs, increasing demand for service, shrinking revenues, and a clear message from the public that increased tax burdens will not be accepted.

The Commonwealth of Massachusetts is home to many institutions which lead the way in medical innovation and service. This has not made us immune, however, to the national health care cost spiral. The Massachusetts Medicaid program currently costs close to $1 billion per year. This represents almost 17¢ spent on every state budget dollar. In addition, the Medicaid budget has grown at a rate far in excess of increases in state revenues.

Massachusetts, and the rest of the states, must seek to provide medical care for its indigent citizens at a price that the public can afford. Resources are limited and health care costs must be contained, in Massachusetts and in the nation as a whole.

Massachusetts has chosen to seek long term control by constructing primary care networks. We call this initiative managed health development. This approach seeks to enroll Medicaid recipients in managed plans of care. It seeks to foster competition among providers and plans, to incorporate potential provider risk and gain as incentives for efficiency, and to offer prepaid reimbursement to improve cash flow and increase flexibility. We feel that this strategy is the only approach which properly recognizes the power and capacity of the private and non-governmental sectors. Increasingly burdensome and cumbersome government regulation will not do the job. Squeezing recipients and providers is a short-sighted, uncreative approach. These forms of "tinkering" with the system are simply not enough. Marginal solutions are not adequate to address the major, systemic problems we face.

We believe that a basic restructuring of the mechanisms by which care is organized, provided, and financed is needed. Only such an approach can deal with our cost problems while maintaining our commitment to high quality, accessible service.

In Massachusetts, we began our experiment into managed health service with the case management demonstration project. Six case management sites were originally chosen, of which 5 are still in the program. Three thousand families (10,000 individuals) or almost 2% of the state's AFDC population participate in the program. The sites include community health centers, a group practice, and hospital outpatient departments.

Case management providers are responsible for managing all care for their enrolled families. This means delivering basic primary care services on-site and referring to secondary providers for specialty services and inpatient care when necessary. All care delivered in a referral setting should be carefully monitored by the case management provider.

By enrolling, recipients agree to permit the case management provider to coordinate their total care. The coordination of care is intended to both increase quality and reduce inappropriate use of specialists, inpatient care, and hospital emergency rooms.

We have observed a number of advantages from case managed care:

1. A consistent, identifiable family physician is made available to enrollees. This is an important marketing device since it appeals to recipients. In addition, the continuity of care it encourages contributes to better health outcomes.

2. "Shopping" behavior was reduced. The locus of care became the primary care provider at the case management site. Random visits to various types of providers were reduced, although a problem I will discuss shortly prevented this benefit from being as great as it might have been.

3. 24 hour telephone call in systems were required at each site, giving enrollees access to information and help more readily than would otherwise have been the case.

4. Case management sites upgraded their medical record keeping systems, in line with project requirements. This enhanced patient management and smoothed referrals.

5. Referral systems were also upgraded in most cases, causing patient referrals to be controlled and tracked more adequately. Although we feel these systems were made better, they were still not strong enough to support a system largely predicated on prudent buying and control of referred services.

A number of problems were encountered which prevented the program from realizing its full potential:

1. Out-of-plan utilization was not adequately controlled. Patients could and did receive unreferred care outside of the case management site and our systems were unable to track such use and deny claims. This difficulty is clearly illustrated by the fact that only between 13%-66% of ambulatory care claims for case management enrolled recipients came from the enrollment site. The rest came from other providers.

2. Our systems have also been unable to track recipients and their costs to allow us to determine the actual cost effectiveness of each site. The status of our information system and data is such that it has required a labor-intensive, time consuming initiative to track pre and post case management cost data for enrolled recipients. The result is that we do not know for sure whether sites saved money. This information will be available, however, later in the month.

3. Provider risk was too limited to cause the changes in provider behavior which fuller risk sharing arrangements would be expected to produce. The fee-for-service orientation of the case management project limited provider investment in the project and caused a situation in which little behavior or practice change could be expected.

4. The elderly and disabled population was not enrolled in the case management project sites. Since the 30% of our cases that represent elderly or disabled recipient categories absorbs 70% of our Medicaid budget, dealing only with the AFDC population limits the costs saving potential of the project.

5. Marketing was difficult, with all but one site ending up below enrollment targets. It is not clear whether this reflects poor marketing technique or the fact that the Massachusetts fee-for-service Medicaid system is so rich that there is no reason for a recipient to voluntarily accept a restriction in terms of where he or she can receive care. There are limited and somewhat vague compensating benefits offered to the recipient for his agreement to limit his access to one provider. But it is clear that most voluntary recipient disenrollments were attributed to individuals not liking the idea of restricted care (46.6%). By comparison not liking the medical care received accounted for only 14.3% of the voluntary disenrollments.

6. Referral systems at the sites were inadequate. Although they did generally improve under the case management project, referral patterns and tracking of referred patients was still weak. A number of patients made self-referrals. Compounding the problem was that Medicaid's after-the-fact review of claims was not timely enough to provide good feedback to providers on utilization by their enrollees. Fuller risk arrangements seem to be the best corrective device for weak referral systems, since at sites put at risk, claims from non-case management providers were reviewed and unauthorized utilization was disallowed for payment by Medicaid.

As we look to continue the case management project and expand both it and other methods of managed health care, it is obvious that we must deal with these problems. We are implementing the following changes to address the problems observed in the case management demonstration project:

1. A new system capability will be in place to control out-of-plan utilization and make the Medicaid card restriction to the managed health provider meaningful. This change, termed the "Medicaid care intercept module" will allow us to find out-of-plan utilization, deny payment, and, if appropriate, sanction recipients. This is a key feature needed to change both recipient and non-managed health provider behavior.

2. Risk arrangements of some sort will be written into all managed health contracts. It is clear that savings sharing arrangements are not sufficiently powerful to change behavior in needed ways. To be sure, the nature of the risk arrangement must be flexible. For example, it is likely that more full risk assumption will be possible with the AFDC population than with elderly and disabled recipients. But some risk assumption, bounded by risk bands where appropriate, will be a prerequisite to future managed health contracting.

3. We will monitor and enforce managed health contracts more strictly than we have dealt with case management project contracts. For example, providers will be required to report cost and utilization information more diligently than they do now under existing contractual requirements. The state will also perform more in accord with the contract, providing more timely utilization reports to providers to allow closer tracking of recipient use patterns.

4. Reimbursement and risk arrangements are now being developed in close association with an actuary. Generally, more professional assistance is being sought in the development of management health contracts and procedures. This will help tighten the system.

5. Many of our planning and program development resources are being invested in analyzing the problem of including the elderly and disabled in managed health. It is essential that we incorporate these high-cost populations into the system if significant cost savings are to be realized.

6. The capacity of a prospective provider to function well as a managed health site will be considered more fully before Medicaid enters a contract. The ability to control, refer, and track patients will be assessed, as will financial viability, quality and access assurance systems, and the presence of the interest and ability to change behavior at the site to manage care.

7. Standards for accessibility will be set and applied for new providers. Geographic and cultural accessibility will be gauged, as well as the ease of access to service at the site.

8. We are in the process of evaluating whether managed health is simply not appropriate for some health settings. For example, our experience in the case management project and subsequent discussions about managed health development suggest that outpatient departments in tertiary care hospitals may not be appropriate managed health care sites. The conflicting goals faced by outpatient departments make it difficult for them to function as care managers. For example, the OPD may need to sanction hospital-affiliated doctors for unapproved services rendered to managed health enrollees. In addition, the hospital may look to the outpatient department to serve as a feeder mechanism for ancillary services. Obviously, a situation like this creates serious internal goal conflict.

9. The other major issue under consideration is the need for and desirability of locking patients into one primary care site and/or physician and ceding all medical and financial responsibility for care to that site or physician.

   We view freedom of choice on a continuum, with the current wide-open fee-for-service system at one end and a system of mandatory enrollment at the opposite end, in which individuals would be assigned to one site and be required to receive all care at that site. We would like to stay as close to the freedom of choice end of the continuum as possible. However, if recipients cannot be convinced to enroll on their own and the capacity of managed health sites expands, action must be considered to provide clients to willing and qualified sites.

   Three issues are relevant here. First, we would ultimately like to be in the position of offering choice to recipients, but choice only among managed plans of care. Second, as budgets continue to be squeezed, the current fee-for-service system may find benefit levels reduced or other changes implemented which make it a less desirable package. Such a situation could well encourage voluntary enrollment into managed health sites. Finally, the Omnibus Reconciliation Act reflects increased flexibility for states to deal with freedom of

choice is as it relates to primary care networks. The time may be coming where choice has to be limited to maintain the financial viability of the Medicaid system.

As I mentioned earlier, Massachusetts has undertaken an ambitious program to expand the availability of and enrollment in managed plans of care. We have done this for several reasons. First and foremost, we believe the managed health concept has real potential for facilitating the kind of systemic change which is necessary if costs are to be controlled in a meaningful way. Second, we believe that the greater continuity and coordination of care made possible under managed health will result in better health outcomes. Finally, once we accept the premise that Medicaid costs must be controlled, a limited number of ways to do the job suggest themselves. First, a strong regulatory approach is possible. Such an approach would mandate government controls on health facilities and services. However, experience with the effects of heavy economic controls in other industries has been poor. We also do not wish to intrude government more heavily into the organization and practice of medicine.

An alternative cost control mechanism would reduce benefit levels and restrict eligibility. This approach would provide fewer services to fewer people. The difficulty with this method is that it makes recipients the payors in cost control efforts. Such a direction is not desirable.

A third savings strategy would reduce reimbursement to providers. This approach is straightforward. However, it applies the burden of cost control unevenly, burdening providers. In addition, this policy could seriously affect the availability of services to Medicaid recipients.

These approaches all have limited utility, are short-term, bandaid solutions, and carry serious negative consequences. As such, we have cast our lot with managed health as the major reform strategy. As we see it, managed health draws on six basic conceptual underpinnings:

- Enrollment: To focus care at one site
- Management: To create a primary care health manager

- Incentives: To reward appropriate and efficient care
- Risk: To give the primary care manager a stake in the outcome
- Capitation: To smooth cash flow and encourage flexibility
- Competition: To promote high quality, accessible, efficient care

The presence of these elements defines managed health care. Obviously, we will be more or less successful at various points in our implementation of incorporating all of these elements to the degree we would like.

We plan to use three principal mechanisms to develop managed health care:

1. Expanded Use of Case Management Sites

   We intend to contract with additional sites to provide care in the model of the case management project. This model, with the changes discussed above, provides a way to obtain the benefits of managed health while using existing organizations. Large-scale expansion will be dramatically slowed if all new enrollment must be into newly developed, special purpose managed health organizational settings.

2. Increased Medicaid Enrollment in HMOs

   In Massachusetts, we currently contract with three HMOs. They enroll 3,000 Medicaid recipients. We believe we can contract with many of the existing 17 HMOs in Massachusetts, thereby significantly increasing the number of our recipients enrolled in managed plans of care.

3. Contracts with Fiscal Intermediaries

   We intend to pursue contracts with one or more fiscal intermediaries to provide managed health services. An intermediary arrangement would be based on a health care organization contracting with Medicaid to provide health services to a defined Medicaid population at a predetermined price. The intermediary

organization would then develop and manage the primary care network through which the enrolled recipients would obtain care. This approach to managed care provides the opportunity for the health care industry to propose and carry out creative options for the organization, financing, and delivery of health care.

We have recently reorganized our Medicaid division to give full attention and support to the managed health development initiative. Managed health development is now one of the four operating divisions of Medicaid, along with program control, operations, and systems.

This managed health organization is divided into four groups. They are planning, recipient issues, provider issues, and operations and control.

The planning group has the following responsibilities:

- Data analysis, to accumulate and manipulate Medicaid data to inform policy decisions on managed health development;

- Reimbursement planning, to set capitation rates for managed health sites;

- Model development, to accommodate the elderly and disabled in managed health;

- Risk analysis, to structure meaningful risk arrangements with providers while assuring that the level of risk assumed is consistent with the level of knowledge about the population group and the capacity to manage the care of that population.

The recipient issues group deals with two areas:

- Marketing, to plan and implement the most promising marketing strategies;

- Quality and access assurance, to develop and apply standards to guarantee that managed health providers offer high quality, accessible care to recipients.

This group is also charged with evaluating options relative to freedom of choice.

The provider issues group also has two major responsibilities:

- Contracting, to assure that contracts with providers are written, negotiated, and monitored properly;

- Vendor development, to develop and carry out a plan to give managed health maximum exposure in the provider community. This involves presenting the managed health concept to providers and their associations, responding to inquiries, and ultimately contracting with new providers.

The operations and control area is responsible primarily for closing the gaps that prevented the case management demonstration project from reaching its full potential. Key areas include:

- Developing a system to control out-of-plan utilization by disallowing claims from providers other than at the enrollment sites;

- Structuring arrangements which will allow Medicaid to pend claims and in turn allow managed health providers to disallow claims from non-referred providers. This is crucial in strengthening the care management role of the managed health provider;

- Calculating savings and risk formulae to be applied to managed health sites.

That summarizes:

- The cost pressures which have encouraged us to pursue managed health solutions;

- The experience of the case management demonstration project;

- The conceptual and organizational approach which the Massachusetts Medicaid program is taking toward managed health development.

We believe that building primary care networks is essential if the Medicaid program is to survive in identifiable form. Managed health offers the best chance of controlling costs while maintaining a high standard of care.

I hope that this conference marks the beginning of concerted effort among states to share experiences on the building of primary care networks. It is a critically important effort and our success is necessary if state Medicaid budgets and good health care for the poor are to survive these difficult, resource-poor times.

Questions and Answers

Panel 2

Q **(Tom Russo, New Jersey)**

How do you handle situations which may arise in the so-called "off hours," something that happens at 3 a.m. or Sunday evening? Mention was made of a 24-hour telephone coverage. If that is not sufficient, what other processes are used to see the patient? Do you have the capability of having a physician available on a 24-hour, 7-days a week basis to see the patient or do you send the patient to the hospital?

A **(Schmidt)**

I think any quality primary care provider should have 24-hour availability of a physician, just by definition, and we do. We will take the telephone call and if it's appropriate see the patient in the office at night. The other aspect--I don't understand why you can't just take away the Medicaid card. That's what we do, and the patient can no longer have the other options. When they come in with their group health card in the emergency room, the emergency room won't service them until we have spoken to them on the telephone. Very frequently we will say that your sore throat is not an emergency, go home and we will see you in the morning. Now you can go ahead and get the care if you are going to pay for it, but the public is not going to pay for it anymore.

A **(Beatrice)**

There's two reasons we can't do that: 1) We don't generally cover these plans all the Medicaid services, so you need a Medicaid card for residual services: eyeglasses, dentistry (we don't cover dentistry) in most of these plans. (2) We write on the card that it is only good at such-and-such a place. But the providers don't take it to heart and deny the care. In the past our systems have been very spotty in their ability to deny that out-of-plan care. So, number one, they have to have a card to get at the things that aren't covered in the plan and it's very clear on the card what it's good for and where, but that's not followed by the providers and our systems don't catch it well enough. On the coverage, in our sites we too, along with having the telephone coverage, required that provision be made for the off-hour care.

A **(Abramson)**

An important answer from our practice is that we have an integrated practice: over half of our practice is private fee-for-service patients. We have to provide those

private patients with services that will keep them coming to us. If we wouldn't provide them with 24-hour access to a physician, we'd lose those patients. If it would be possible to develop programs such as Group Health has in an integrated fashion, that problem is going to take care of itself. Those doctors have to provide coverage or they are going to loose their private patients.

Q **(Russo)**

As a corollary, how would you provide such coverage in a highly urban area where you have security problems, where people are afraid to go out at night and the physician probably is almost as afraid to go to his office because of security problems? How do you overcome that situation?

A **(Abramson)**

We do do that. There are two different ways: (1) the door to our practice is locked and there is a closed circuit security system throughout the hospital which our office also shares in, so that we actually do go down and meet those patients in the middle of the night in that office. The door won't be open unless the operator sitting at the desk perceives that somebody who is supposed to be there is going to be there. If it's a true emergency, then we'll meet those people in the emergency, and there's obviously adequate security there.

A **(Belangy)**

I would like to respond also, if I may. We too have 24-hour a day coverage. We had had a contract with a private group in the community called Housecalls, Inc. What we have done recently is we have used our 24-hour emergency care line, staffed it with a nurse practitioner with consultation available from one of our primary care physicians on an on-call basis. We have found that most all of those calls coming in after hours and on week-ends have been able to be handled over the phone by the nurse practitioner, without additional consultation with the physician or a referral to the emergency room.

Q **(Simenstad)**

I have a question for John Abramson. I'm aware there is a family practice unit also in the University of Wisconsin. Are your bricks and mortar costs included in your calculations? If you're living in sight at the hospital, that's a little different than in private practice when you're paying more for bricks and mortar and other expenses. That's one reason why maybe you can get by. Would you want to comment on that?

A **(Schmidt)**

We were set up on a private practice mode. I paid $65,000 per year rent, and I pay every personnel I hire. That's one reason we're so cost-conscious. There is subsidy for teaching, of course. There are federal grants. But for the actual running of the

practice, we have to hustle just like every private provider. If we're doing this well, what is the private physician in the plush suburb with a community hospital doing under this plan? Our expenses are tremendously high. We don't have the usual subsidy that a teaching program has.

Q **(Hansen)**

Two questions. First, do you have any administrative costs of setting up the primary care networks? Secondly, both of these programs are relatively small thus far. Can you say anything about how your experience might be extrapolated to a larger scale?

A **(Belangy)**

The answer to your first question on administrative costs is no, we do not. The operation of our clinic system has broken out administrative cost to include all clinic functions, not just Multicare. It's one of those data bases we need to develop in the next few months so that we can extrapolate out that cost as well as the service cost just for Multicare. The second question is a very important one and the question is usually put to us: "Well, if Project Health is so successful, can't it be replicated in other areas?" Obviously, if you're looking at a consumer choice competition model, the success of that lies in the availability of plans in the community where you have one or more HMOs available to contract with. So you have some rural areas where you probably don't have that situation. I think if you look across the county in the major population areas, however, you by and large will have those plan arangements available to you.

A **(Beatrice)**

Regarding the first question on administrative and start-up cost, the people we've contracted with thus far have been existing organizations, like a neighborhood health center. They pretty much have met their start-up costs. To come into this plan with us, their additional costs are very slight. So that's not an issue that we've confronted directly yet. We realize that we're going to have to. As for expansion, we think there is a real market out there. We've gotten a lot of expressions of interest from clinics, health centers, individual physicians, certain community hospitals, all of whom want to be case management sites. I don't think that's the issue. For us the problem is, "What kind of a model are we going to be able to go forward with?" Will it have to be the very fee-for-service dependent model that the case management project has been, or are we going to be able to move more quickly to a managed health, more integrated, more capitated risk-assumed model. That's the question. We know we're going to get up a lot of sites and get a lot of people in. The question is how close to the ideal managed health model are we going to be able to come to right away.

Q **(Alan Wheeler, New Jersey)**

I'd like to ask the two physicians: In your direct referral, do you set the fee?

A **(Schmidt)**

No. We are developing relationships with certain groups and we know what their fee schedules are, but it's just like a physician in any community under fee-for-service system. If one consultant provides excellent service and gives you a referral, you use him again. Now we just add that additional factor of cost. For instance, if I send someone to a neurologist for a headache and the patient really just wants a second opinion, I don't have to go to the head of the department of neurology. You don't really need that level at $150 an office visit. One of the other people at a lower price is quite appropriate.

Q **(Wheeler)**

What happens if the Medicaid patient with GHP here has other insurance? If the family had Blue Cross, how does it interface?

A **(Davis)**

We're responsible for tracking all other third party payments.

Q **(Russ Schwartz, New York)**

I was struck that the Oregon experience has the most obvious difficulty in adverse selection and that your solution to that at this point is a relatively simple, practical and attractive one of sorting out relative need in a non-medical setting. I'm wondering what the feeling of other primary care providers is on this issue. Is it your thinking that a non-medical solution is likely to work?

A **(Schmidt)**

I think you probably have a favorable selection in a sense that the recipient has to do something, has to be put together enough so that they can pick up the telephone and get something going. As John says, we're looking at pre-enrollment behavior and costs and comparing that to enrollment to see if that really is true. But our impression is that we're probably getting a favorable selection.

A **(Beatrice)**

That's our belief too. The way we see it, the individual that's likely to choose an arrangement like this is someone who doesn't have an ongoing relationship with a provider or a number of providers. The person who is most likely to have that on-going arrangement is someone who has used services as needed. Therefore, you are more likely to get the light users or the non-users joining a plan rather than someone who would have to disrupt an established relationship. That's a concern because we don't want to price ourselves at an average utilization figure--or even a high utilization

figure--if in fact the enrolled population are going to be lower users. So that's a tough reimbursement problem we face.

Q **(Bartlett)**

John, you and David and Max have given us a real good idea of how your plan works and what your responsibilities are. Unfortunately, Stan Sells (the Ohio Medicaid Director) isn't here, so I'll look to you folks to explain a little bit about what the role of the state Medicaid agency is in dealing with you. What does it have to do in order for this thing to work?

A **(Davis)**

That's a very pertinent question, Larry. Stan Sells, Ken Crease and the others in the administrative section of our Department of Public Welfare worked very closely with us. We started this on a very interesting basis. We originally got our entry into the Department of Public Welfare through our Region V of HEW, working with John Dye at that time and Ky Santiago. Ky Santiago was the head of the Bureau of Community Health Services, John Dye was the head of Medicare-Medicaid Division. We put together a little package and we approached the then director of public welfare in Ohio, and after about a year's effort in talking to him about the rationality of this, it turned out that we were on the same wavelength. This is the way things occur. That was about three-and-half years ago. Since then we've had excellent relationships. Stan was in Washington with us at a conference following the Group Health Institute on Medicaid and HMOs. We presented this same material then--unfortunately, we did not have John or David there at that time; that would have been very good. We've been approached now by Alain Enthoven, by Carolyne Davis, and Representative Gephardt to project our models into the public arena. Our HMO took the position, and as I mentioned before, a lot of HMOs did not, that the publicly funded patient was an important source of development for HMOs. Actually, HMOs have possibly more of a function for the publicly funded patient than the privately funded patient because of the access difficulties that publicly-funded patient has in getting appropriate health care. We pushed that along pretty strenuously. In this last year for the next budget period, we've had our BCHS grant reduced to the point that we can only provide ambulatory care for BCHS population. Well, we decided that wasn't possible, that's against our genetic code again. So we have now devised a system where the co-pay that we collect from the BCHS enrollee on a sliding scale basis will cover the in-patient care. But we will not disturb the essential relationship that we have with that member of GHP. He receives the same care as the Medicaid patient, the Medicare patient, or the private-pay or non-group patient. I think the state looks upon this as a

good resource. We have aproposal before the State of Ohio to take over an entire county's ADC population. They look favorably upon it, as does the County Welfare Director. Unfortunately, there's a threat that EDS may be taking over the state's entire Medicaid apparatus. They are sort of greasing the skids for that. So we have the politics to deal with. We have had very good cooperation from our State Department of Public Welfare. Our capitation to them (Jim Tye has made some analysis from around the country), is one of the lowest capitations for the entire complex. Our premium for the state is $50.50. That covers medical, dental, eye glasses and pharmaceutical, and we still make a little bit of money on that. I think it's through good case management that this can be done, with the help of people like John and Dave here. You can see the attitudes of physicians are of paramount importance.

Q Do you have any reinsurance arrangement?

A **(Schmidt)**

Yes, all kinds. The basic contract has some maximum liability provisions. GHP, the HMO has the reinsurance policy to protect its providers.

Q **(Jerry Radke, Pennsylvania)**

In Pennsylvania two years ago the state tried to set up a number of Medicaid-only HMOs and it turned out to be a real disaster. We're still in litigation trying to figure out who should pay whom. We've adopted a posture right now of trying only to do business with the federally qualified HMOs, and really not to overwhelm them. As it turns out there's six federally qualified HMOs in Pennsylvania. We have contracts with two, and I think we have fewer than 2,000 recipients covered under HMO. Because of what Massachusetts is doing and the Arizona experience, we're now starting to get pressure to create something along the lines of Massachusetts, instead of waiting for the HMOs to grow and let us buy in. I'd just like to ask you, if you were a physician in Pennsylvania, what would be your preference?

A Just to make one comment. We aren't dealing with all Medicaid HMOs. We're dealing with existing HMOs that have a small percentage of their populationcoming from Medicaid enrollment. We have no intention, in fact, of setting up plans just to deal with the Medicaid population. We think the dangers are just not worth it. I think the key is that we aren't creating anything. If the neighborhood health center is in a part of the state where it turns out that normally--without us doing anything-- it's population is 80 percent Medicaid, that's simply dealing with an existing reality. We can't bus people in to use the neighborhood health service. I think the key is to not to

go out of your way to set up a system to just care for the Medicaid population. If they live together in an area and there is a facility to serve them which has a very heavy Medicaid census, there's really nothing as a practical matter you can do about that.

A **(Schmidt)**

I'm going to give you an impression, but it's not an answer to your question. I feel very strongly that the solution to the health care needs of the indigent is to mix them with middle class. There is no other solution. Bring everything up to one high standard.

A **(Belangy)**

That's been very much our experience in Oregon. The open paneled, high-cost option plans tended to attract a disproportionate share of the very high-risk, high-utilizing population and it did, in fact, have an adverse financial impact on those plans. I think it's important that that population be disbursed. One of the attractive aspects of the Group Health of Northeast Ohio is the fact that they have been able to mix populations. It has been an integrated population. They're serving not just a poor population which has higher health care needs than, for example, an employed population. That's the direction that we're looking toward moving.

Q **(Radke)**

In talking to some of our HMOs in Pennsylvania, we're saying that we're going to pay good money--and we would be paying more than what a major employer would pay--and yet we still have trouble getting them to agree to do business with us. I'm not sure it's just the dollars involved. A lot of our HMOs are in the urban areas, and that's why I was curious about the Cleveland experience. You have the really well integrated patient population.

A **(Schmidt)**

Absolutely. As I said, the President of the University will sit right next to a black inner-city person and that's just the way it is. It's non-negotiable. If people want it, they're more than welcome to join us and if they don't, then they can go somewhere else.

A **(Abramson)**

There's a slight difference in the way you are framing the question. HMOs haven't been created. There's a minimum of administrative mechanism around. The Group Health Plan central office sits downtown and no patients see that unless they have an administrative problem. I think you might do better to negotiate with private physicians who are seeing some of those patients anyway and set up a mechanism where they could accept the Medicaid patients on a prepaid basis. It's much less of a change in the structure of the delivery of medical care.

Q **(Radke)**

But you as providers have someone (GHP) standing between you and the state welfare department. If the State of Ohio had approached you directly with the same deal that Group Health Plan is offering, would you have taken it?

A **(Schmidt)**

No, I don't think so. There would have been no reason for me to have done this. I just knew that this Group Health thing was around, looked at it, and thought about it, and finally jumped in.

Q **(Abramson)**

Jerry, are you saying that you like to see the state manage something like this itself?

A **(Radke)**

No. I was just sitting here thinking that Erie is so close to Cleveland--I'll pay you the Ohio rates (laughter).

A **(Schmidt)**

This is a real possibility that some plan like Group Health will go national and serve as the broker.

Q **(Curtis)**

The State of Michigan, which is on the next panel, is basically looking at a Medicaid-only case management model. They're looking at doing it in a very big way in Wayne County where they already have a higher participation rate in HMOs than any other location in the country. As I understand, they are going to have two options: the case management option and the traditional HMO. They're talking about the state as the fiscal intermediary for the case management model. I think there's a very important distinction between the problems that Pennsylvania, California and a couple of other states had with Medicaid HMOs awhile back and this kind of model. That is that there were very powerful incentives in those cases to deny any care, powerful incentives to deny access to hospital care. In the case of the carefully designed primary care network, they are moderate fiscal incentives. There are ways that providers can keep track of what their cost experience is as a result of the way they are delivering care, but there are not powerful fiscal incentives to deny needed care. I think that's a very important distinction and a distinction that will allow states to use this model in areas where there are not existing HMOs and there are not existing Blue Cross/Shield or other intermediaries that are willing to put them up. That's one of the reasons some of us are very excited about the model. I think it does have the potential for use with Medicaid recipients only.

A **(Schmidt)**

To go back to the original question, would a private provider work with the State of Ohio, I believe it's correct that Max has more efficiency and more staffing in his little operation than in the whole state of Ohio. In no way would I trust state officials to do my insurance business.

PANEL THREE:

WHAT STATES ARE DOING TO IMPLEMENT PRIMARY CARE NETWORKS

Included in this section are the presentations by the following representatives from states which are actively planning the implementation of primary care networks within their state Medicaid programs.

Maryland

Lyda Sanford
Chief, Division of Program Development
Maryland Department of Health and Hygiene

Michigan

Sherry N. Wellman
Public Policy and Political Affairs
Michigan State Medical Society

and

Bruce Hansen
Director, Medicaid Policy Division
Michigan Department of Social Services

AN INVESTIGATION OF RECIPIENT CARE SEEKING BEHAVIOR AND ITS COSTLY IMPLICATIONS FOR MEDICAID

Lyda Sanford
Chief, Division of Program Development
and
Patricia Velnosky, Research Associate
Maryland Department of Health and Mental Hygiene

Introduction

The potential for significant change in the manner in which Medicaid programs structure primary care services, brought about by PL 97-35, is being examined with interest in Maryland. Two recent occurrences have heightened that interest: the possibility of a sizable Medicaid fiscal deficit, and a recent recommendation (in light of both past history and the potential deficit) for the Program to experiment with primary care case management. In order to assess the appropriate response to our new federal flexibility, studies were undertaken to examine both recipient care seeking behavior and provider practice patterns, and their impact on Medicaid ambulatory and inpatient expenditures.

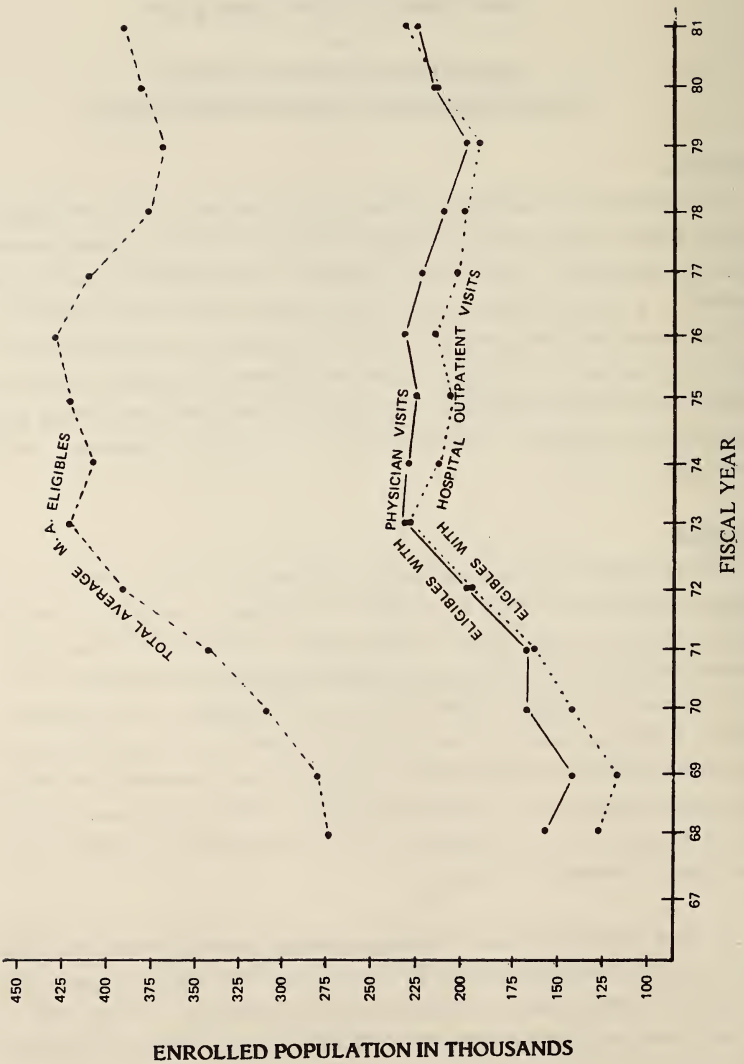
Background

Maryland Medicaid has traditionally experienced very high utilization of hospital outpatient departments (OPDs) by recipients. Maryland is exceeded by only the Virgin Islands in percent of total Program budget paid for outpatient department care. In fact, statewide utilization of OPDs equals statewide utilization of physicians office services, both in number of eligibles using the services (200,000+) and the number of visits (700,000). With fiscal year 1981 data recently available, the number of Medicaid eligibles using hospital OPDs has exceeded those using office based physicians for the first time in the Program's fourteen year history (see Figure 1). Although the ratio of OPD visits to physician office visits is 1:1 statewide, it is 2:1 in Baltimore City, which has the largest concentration of Medicaid recipients.

To make this all the more interesting, average reimbursement for a hospital OPD visit was $54.09 (including ancillaries) in fiscal year 1980 while average reimbursement for a physician office visit was $14.87 (including ancillaries). Not only were recipients using two times more OPD services than physician services, each visit was costing three times as much!

Figure 1

Physician vs. Outpatient Utilization for Medicaid Eligibles



We asked ourselves if we couldn't more prudently spend our ambulatory care budget, and convened a task force to examine this issue. It was while we were pulling together previously unresearched data for the task force that an interesting picture began to emerge as we examined the patterns behind the reported data.

For instance, although there were over 1,000 physician accounts with a Baltimore City address, only 696 had actually billed Medicaid for an office visit, according to an examination of 1979 data. Even worse, one third of those accounts had billed for ten patients or less, and two thirds had billed for fifty patients or less. Only 210 accounts had seen over fifty patients, and only 24 accounts had seen over 1,000 patients. It seemed that, for whatever reasons, physician services are not as accessible to Medicaid recipients as hospital services are.

Methodology and Results

A. Study of Recipient Care Seeking Behavior

We decided to examine, in some detail, care seeking behavior of Baltimore City recipients. A random sample of 400 Baltimore City Medicaid cases was drawn from our eligibility file. The sample was comprised of 776 individual eligible recipients. Based on age and category of eligibility, the sample closely resembled the Baltimore Medicaid population. The paid claims file yielded their utilization of Program services for a one year period (calendar year 1979).

In examining services billed for these recipients during CY 79, visits were taken as the primary measure of utilization. Since these data were hand tabulated, we selectively limited the study to major service settings: physician visits, hospital outpatient visits and emergency room visits. Recipients were judged to be either "users" or "non-users" of this type of care. Use of inpatient services was correlated with ambulatory visit behavior, and also examined. Recipient care seeking behavior was characterized by five utilization patterns:

1. Outpatient Department only - recipients who used only OPD sources for ambulatory care;
2. Outpatient and Emergency Room only - recipients who used only OPDs and ERs for ambulatory care;
3. Emergency Room only - recipients who used only ERs for ambulatory care;
4. Physician only - recipients who used only physician sources for ambulatory care (N.B.: this includes free-standing comprehensive community care sites);

5. Mixed - recipients who used physician sources, OPDs, and ERs for ambulatory care.

Within these care patterns the number of actual care sources used by a recipient was also tabulated. Even though this kind of measure does not distinguish between referrals made by providers and decisions made by recipients as to where to seek care in a given instance, it does give a general idea of the extent to which recipients sought care from multiple sources.

The samples' distribution by pattern of care is shown in Table I. The two most apparent results are the large percentage of sample recipients (41.8%) with no source of ambulatory care and the large percentage of users tied to outpatient care sources. Nearly 50% of the entire sample--83% of the users--had some form of hospital ambulatory care utilization, either OPD visits or ER visits. The largest group of users were in "OPD only" category.

For those who showed no ambulatory care source, a further examination disclosed some to have used inpatient service only, or to have been enrolled in an HMO. However, the largest group of non-users simply made no Medicaid reimbursed visits. It should be remembered that many of these non-users may well have used services that were not considered in this analysis--i.e., special services, dental, pharmacy, home health, and nursing home services. Services rendered to HMO enrollees are not documented in Medicaid claims records (since fee-for-service claims are not paid for these persons); thus, those utilization data were unavailable.

The extent to which recipients used the various sources is shown in Tables II and III. Separating the patterns of use in terms of institutional and non-institutional care sources, Table II shows the percentage of recipients using each source and the intensity of ambulatory and inpatient utilization associated with each source.

Those using institutional sources had a higher average number of visits and a higher average of hospital inpatient days than those using only non-institutional sources. Institutional users averaged 4.4 visits and 2.2 hospital days as compared to non-institutional care users who averaged 2.9 visits and .4 hospital days. This is in-spite of the fact that most institutional users had only one source of care (see Table III). Perhaps, not surprisingly, the use of different sources increased the average

TABLE I

CARE SEEKING BEHAVIOR IN
THE BALTIMORE CITY MEDICAID RECIPIENT SAMPLE

Ambulatory Care Source		No. Recips.	% Sample
A.	OPD Only	173	22.3
B.	OPD and ER	64	8.2
C.	ER Only	27	3.5
D.	Physician Only	77	9.9
E.	Mixed	110	14.2
	Sub Total	451	58.1
F.	No Ambulatory Source		
	Inpatient Only	12	1.5
	Non-User	248	31.9
	HMO Enrolled	65	8.4
	Sub Total	325	41.8
	TOTAL SAMPLE	776	99.9

TABLE II

AMBULATORY AND ACUTE INPATIENT UTILIZATION
BY THE BALTIMORE CITY MEDICAID RECIPIENT
SAMPLE CARE USERS

Ambulatory Care Source	% Users of Ambulatory Care	$\bar{x}$ No. Visits	$\bar{x}$ Hospital Inpatient Days
I. Institutional	58.5	4.4	2.2
A. OPD Visits Only	38.3	4.1	2.0
B. OPD and ER Visits Only	14.2	6.4	3.4
C. ER Visits Only	6.0	1.4	.3
II. Noninstitutional	17.1	2.9	.4
A. Physician* Visits Only	17.1	2.9	.4
III. Mixed Sources (OPD/ER/Phys.)	24.4	7.5	1.2
A. Only two mixed care sources (one institutional, one non-institutional)	12.0	5.8	.7
B. More than two mixed sources	12.4	9.2	1.7
	100.0		

N = 451

* Includes freestanding clinics such as neighborhood health centers, reimbursed under the Physicians' Program.

TABLE III

DISTRIBUTION OF NUMBER OF CARE SOURCES BY PATTERN OF CARE: BALTIMORE CITY MEDICAID RECIPIENT SAMPLE

Ambulatory Care Source	No. Recips.	No. Ambulatory Care Sources 1	2	3	4+
I. Institutional	264	193	56	12	3
A. OPD Visits Only	173	140	28	4	1
B. OPD and ER Only	64	29	25	8	2
C. ER Visits Only	27	24	3	–	–
II. Physician Visits Only	77	57	13	2	5
III. Mixed Sources	110	NA	54	34	22
Totals	451	250	123	48	30
Percentages		55.4	27.3	10.6	6.7/100.0

number of visits. For those using both institutional and non-institutional sources, the average visits jumped to 5.8 for those with two mixed care sources and 9.2 for those with more than two mixed sources.

As previously mentioned, Table III shows the distribution of care sources for the number of recipients using each care pattern. The overwhelming majority in each pattern used only one care source. Even those people using mixed sources generally confined themselves to only two different sources.

It might be easy to hypothesize that the groups using more than two mixed sources is sicker and therefore needed to use more services; however, their use of inpatient services is quite low--1.2 days. Another possibility is that a relationship with a physician (even though weak) has some negative effect on inpatient utilization. This led to speculation concerning the effect of care setting on provider practice patterns.

B. Provider Practice Pattern Study

Based on the findings of our preliminary study on care seeking behavior, an analysis was undertaken to examine the utilization behavior of persons receiving care from selected physicians, neighborhood health centers, and hospital OPDs. Utilization of ambulatory and inpatient services was examined for a representative sample of recipients using these providers:

- four office-based primary care physicians with large Medicaid practices;
- three neighborhood health centers (CHCs 1-3);
- one free-standing comprehensive primary care clinic system (CHC 4);
- two large inner-city teaching hospitals' outpatient departments.

Hoes does care source influence total Medicaid costs per recipient? To what extent does provider type influence recipients' exhibition of care source loyalty? Who represents competition for whom? These questions motivated our study.

The time period chosen for analysis was July 1980 to June 1981 (FY 81). In the absence of computer sampling capability, the samples were hand-drawn from microfilmed provider payment records. The only criteria was that the recipient must have made at least one ambulatory visit to that provider. Due to the

burdensome method of selection and the necessity for hand-tabulation of the resulting data, the samples were only as large as statistically necessary. (CHC 4 was the subject of another study, thus has a 33% sample.) As in the first study, complete service utilization for each sample recipient was obtained from the individual payment history files. All major ambulatory care services visits (i.e., to physicians, free-standing primary care clinics, hospital OPDs, and ERs) and all hospital inpatient claims paid during that period were considered.

For each sample, the number of visits made to the provider from whom the sample was drawn (i.e., the source provider) were totalled along with the number of "non-source" provider visits. Days of inpatient care and number of hospital admissions were counted and averaged across each sample. Total cost to Medicaid per recipient was averaged for each of the samples (see Table IV). This information, presented in Table IV, is surprising in some respects:

- only one CHC, two of the physicians, but both hospitals' samples had more visits to "source" than non-source providers,
- the two hospitals "captured" the majority of total visits their samples made; the average visits made to them were almost twice as high as the next highest provider (physician #1),
- hospital inpatient utilization divides the samples into two groups: low to moderate (the CHC and physician samples) and high (the hospital OPD samples),
- the extreme range of average total cost to Medicaid, from $236.88 per year to $2,144.16 per year.

Prior to presenting further results, a few comments on the data set need to be made. In preliminary calculations it was discovered that there were individuals whose excessive use of inpatient services skewed their samples on that measurement and on the total average cost per recipient. To correct for this, a cut-off point was established for these outliers; individuals whose total yearly inpatient utilizations (days) fell beyond 2.5 standard deviations from the mean for that provider type were deleted. This affected one person in the CHC group, three persons in the physician group and ten persons in the hopsital outpatient group. The effect of deleting these individuals was negligible on the samples' total ambulatory utilization.

TABLE IV

SAMPLES' AMBULATORY AND INPATIENT BEHAVIOR: USE OF SOURCE AND NON-SOURCE PROVIDERS

General Information	Comprehensive Health Centers				Physicians				Hospitals					
	CENTER 1	CENTER 2	CENTER 3	CENTER 4	PHYS. 1	PHYS. 2	PHYS. 3	PHYS. 4	HOSPITAL 1			HOSPITAL 2		
Estimated Number of Medical Assistance Patients - 1 year	3,000	2,400	2,100	1,200	840	1,200	1,700	1,140	39,000			27,000		
Sample Size	145	147	103	426	67	78	88	74	394			239		
% of Estimated Patients	5%	6%	5%	33%	8%	6%	5%	6%	1%			.9%		
Ambulatory Visits Utilization														
Visits to Source Provider	414	373	272	1,137	370	299	270	339	3,417			2,222		
Average Visits Per Recipient	2.85	2.54	2.64	2.67	5.52	3.83	3.07	4.46	8.67			9.30		
Visits to Non-Source Provider	295	640	327	1,320	186	273	481	684	1,009			617		
Average Visits Per Recipient	2.03	4.35	3.17	3.10	2.78	3.50	5.47	9.24	2.56			2.58		
Hospital Inpatient Utilization	CENTER 1	CENTER 2	CENTER 3	CENTER 4	PHYS. 1	PHYS. 2	PHYS. 3	PHYS. 4	Source	Other Hospital	Total Hospital	Source	Other Hospital	Total Hospital
Days of Inpatient Care	100	99	45	374	10	49	144	51	1,304	299	1,603	560	139	69
Admissions	21	19	13	81	2	9	25	10	174	31	205	103	22	12
Average Days Per Admission	4.72	5.21	3.46	4.62	5.00	5.44	5.76	5.10	7.49	9.65	7.82	5.44	6.32	5.5
Average Days Per Recipient	.69	.67	.44	.88	.15	.63	1.64	.69	3.31	.76	4.07	2.34	.58	2.9
Average Cost Per Recipient	$459.78	$498.48	$296.37	$567.89	$236.88	$634.65	$999.78	$724.53	$2,155.16			$1,689.14		

Table V shows the average utilization, for both ambulatory and inpatient services, for recipients in each of the ten samples. Results are also shown for Aid to Families with Dependent Children (AFDC) subsets of each sample.

Of all the data presented in Table V, we found the most interesting to be:

- the homogeneity of visit behavior within both the comprehensive health center data set and within the hospital outpatient data set;
- The ascending average ambulatory visit rates, from six per recipient for the CHCs, to nine per recipient for physicians, and ten per AFDC recipient for the hospital outpatient departments;
- the variability of visit behavior within the physicians data set, which is not mitigated when only the AFDC group is examined;
- the immense difference in average hospital inpatient utilization for the AFDC subsample of the OPD samples as compared to the AFDC subsamples of both the physicians and comprehensive health centers samples.

We have attempted to control for case mix severity across provider types by also tabulating and presenting utilization averages for the AFDC subset of the samples. Initially, this was done to address the issue that the samples taken from the two hospitals were perhaps very different from those taken from the other providers. From the limited information on our payment files, it was impossible to select samples from a general clinic within each hospital. Under our reimbursement system all hospital clinics bill under that hospital's provider number. Therefore the OPD samples represent individuals that were seen in all types of OPD clinics, both general and specialty. This sampling was bound to include a number of sicker patients, both those with severe acute illnesses and those with chronic ailments. By describing AFDC utilization as well as total sample utilization, we at least delete those categories of recipients eligible because of age or chronic illness.

The average cost per recipient by care setting is described in Table VI, for both total samples and the AFDC subset of each sample.

Figure 2 is visual representation of the combined average utilization and cost for users of the comprehensive health centers, the physicians and the hospitals. The corresponding information on the AFDC subsets is shown in Figure 3.

TABLE V

AVERAGE ANNUAL VISITS/RECIPIENT BY TYPE OF PROVIDER VISITED FOR VARIOUS SAMPLES

		AVERAGE PHYSICIAN VISITS	+ AVERAGE OPD/ER VISITS	= AVERAGE TOTAL AMBULATORY VISITS	AVERAGE HOSPITAL INPATIENT DAYS
I. COMPREHENSIVE COMMUNITY HEALTH CENTERS					
A. Health Center 1					
Total Sample	N = 145	3.52	1.37	4.89	.69
AFDC Subset	N = 122	3.45	1.23	4.68	.78
B. Health Center 2					
Total Sample	N = 147	4.23	2.66	6.89	.67
AFDC Subset	N = 134	3.94	2.61	6.55	.57
C. Health Center 3					
Total Sample	N = 103	3.99	1.83	5.82	.44
AFDC Subset	N = 81	4.25	1.96	6.21	.20
D. Health Center 4					
Total Sample	N = 426	3.68	2.09	5.77	.88
AFDC Subset	N = 367	3.79	1.98	5.77	.77
Total Community Health Centers	N = 821	3.79	2.03	5.82	.75
Total AFDC Subset	N = 704	3.81	1.97	5.78	.67
II. OFFICE BASED PHYSICIANS					
A. Physician 1					
Total Sample	N = 67	7.24	1.06	8.30	.15
AFDC Subset	N = 64	7.14	1.03	8.17	.03
B. Physician 2					
Total Sample	N = 78	5.13	2.21	7.34	.63
AFDC Subset	N = 37	5.70	2.59	8.29	.92
C. Physician 3					
Total Sample	N = 88	4.45	4.08	8.53	1.64
AFDC Subset	N = 55	4.42	4.45	8.87	1.49
D. Physician 4					
Total Sample	N = 74	9.00	4.85	13.85	.69
AFDC Subset	N = 29	10.21	1.83	12.04	.17
Total Physician Sample	N = 307	6.33	3.12	9.45	.83
Total AFDC Subset	N = 185	6.52	2.49	9.01	.66
III. HOSPITAL OUTPATIENT DEPARTMENTS					
A. Hospital 1					
Total Sample	N = 394	1.05	10.19	11.24	4.07
AFDC Subset	N = 236	.82	8.53	9.35	2.28
B. Hospital 2					
Total Sample	N = 239	1.31	10.56	11.87	2.92
AFDC Subset	N = 135	1.30	9.36	10.66	2.13
Total Hospital Sample	N = 643	1.15	10.33	11.40	3.64
Total AFDC Subset	N = 378	.99	8.83	9.82	2.22

NOTE: OPD and ER visits are not distinguished separately on this table since one of the hospitals is unable to separate their own OPD and ER visits.

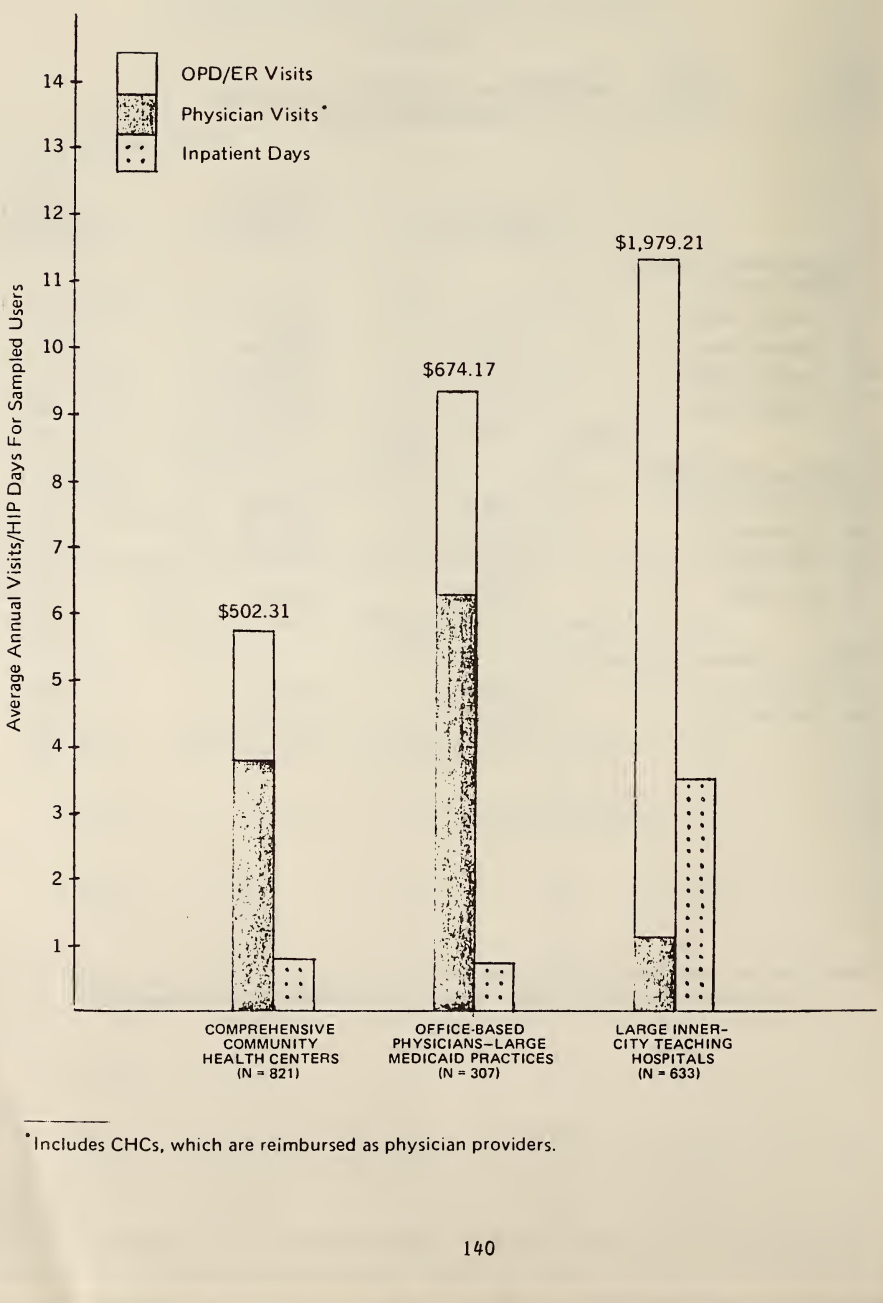
TABLE VI

RECIPIENT AVERAGE COST TO MEDICAID BY CARE SETTING

	Total Sample (N=1761)	AFDC Only (Subset) (N=1260)	AFDC Percent of Total Sample
I. Comprehensive Community Health Centers			
A. Health Center 1	$459.78	$505.25	84.1
B. Health Center 2	$498.48	$457.46	91.2
C. Health Center 3	$296.37	$272.42	78.6
D. Health Center 4	$567.89	$537.09	86.2
Average	$502.31 (N=821)	$485.97 (N=704)	85.7
II. Office Based Physicians			
A. Physician 1	$236.88	$210.21	95.5
B. Physician 2	$634.65	$690.36	47.4
C. Physician 3	$999.78	$870.02	62.5
D. Physician 4	$724.53	$596.90	39.2
Average	$674.17 (N=307)	$563.02 (N=185)	60.3
III. Hospital Outpatient Departments			
A. Hospital 1	$1689.14	$1499.52	56.5
B. Hospital 2	$2155.16	$1418.36	59.9
Average	$1979.21 (N=633)	$1447.89 (N=371)	58.6
TOTAL AVERAGE	$1063.15	$780.51	

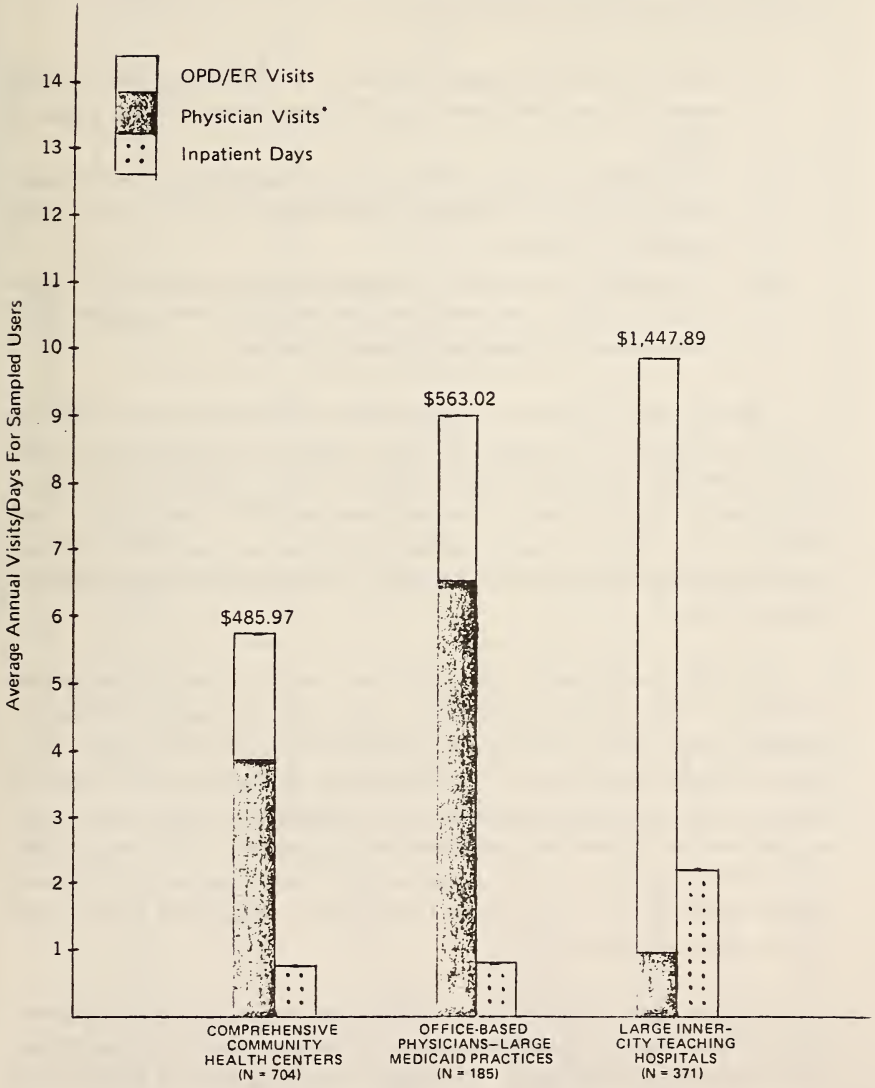
Note: Average costs represent all Medicaid covered services (except pharmacy and nursing home care) reimbursed in FY 81, divided by the number of individuals in the samples.

Figure 2: DISTRIBUTION OF AVERAGE ANNUAL VISITS, INPATIENT DAYS, AND AVERAGE COST BY DIFFERENT TYPES OF PROVIDERS FOR ALL SAMPLED RECIPIENTS



*Includes CHCs, which are reimbursed as physician providers.

Figure 3: DISTRIBUTION OF AVERAGE ANNUAL VISITS, INPATIENT DAYS, AND AVERAGE COST BY DIFFERENT TYPES OF PROVIDERS FOR SAMPLED AFDC RECIPIENTS



* Includes CHCs, which are reimbursed as physician providers.

These two figures graphically depict some of the major differences and similarities between provider types, such as:

- the not surprising similarity between the total sample and its AFDC subset for the CHCs (after all, a majority of their total sample is AFDC);
- the surprising similarity between the total sample and its AFDC subset for the primary care physicians (whose users were not heavily AFDC recipients--see Table VI);
- the continued large cost discrepancy between the non-institutional providers (CHCs and physicians) and hospitals even for the AFDC subsets, especially regarding inpatient utilization.

Table VII shows the extent to which members of each sample use other care sources in addition to the sampled provider. Recipients are identified as "loyal users" if they used only the sampled provider for their ambulatory care and as "regular users" if they used the sampled provider for at least 50% of their ambulatory care. Persons using the sampled provider for at least 50% of their care may be regular users of some other source of care, but made sporadic visits to a sampled provider.

All sample members using other care sources were assigned to care patterns according to which services were used. Some used the source provider and OPD/ERs; some used the source and physician(s); some used the source and a mixture of other provider types. Within particular care patterns the number of "regular users" was counted, along with the percentage of visits made to the sampled provider by the entire group within the care pattern. For example, within the "mixed" pattern for Physician 1, almost half (7) of 13 people were considered "regular users" but, as a group, those 13 individuals averaged half of their total visits to the source physician.

In examining the degree of attraction providers have on individuals using their services, there seems to be great variance in the percentages of "loyal users" both across and within provider types. Percentages of "loyal users" vary from 20 to 40 percent for CHCs and 16 to 35 percent for physicians. The percentages of "regular users" for these provider types is slightly more consistent. Counting both "loyal"

TABLE VII

CARE PATTERNS AND PROVIDER LOYALTY–ALL SAMPLES

Competition and Market Share	Comprehensive Health Centers				Physicians				Hospitals	
	CENTER 1	CENTER 2	CENTER 3	CENTER 4	PHYS. 1	PHYS. 2	PHYS. 3	PHYS. 4	HOSPITAL 1	HOSPITAL 2
Physician										
Number Using Source and Physician(s)	16	22	10	58	15	12	7	15	56	51
Number of Regular Users	9	12	4	29	7	6	6	6	48	40
% Visits to Source	44.0%	37.6%	42.8%	47.2%	45.0%	61.3%	71.4%	50.6%	76.2%	72.5%
OPD/ER										
Number Using Source and OPD/ER(s)	50	45	42	141	16	19	33	16	78	43
Number Regular Users	36	22	24	62	13	12	12	7	61	34
% Visits to Source	53.9%	46.3%	44.3%	44.5%	75.7%	57.0%	30.4%	26.6%	75.8%	77.5%
Mixed										
Number Using Source and Both Physician(s) and OPD/ER(s)	17	50	20	97	13	20	32	31	52	34
Number Regular Users	2	9	4	33	7	6	5	7	19	17
% Visits to Source	29.8%	24.2%	22.3%	32.4%	49.1%	34.0%	31.0%	28.2%	36.1%	47.5%
Number and % Regular Users/Sample	47	43	32	124	27	24	23	20	129	91
	32.4%	29.3%	31.1%	29.1%	40.3%	30.8%	26.1%	23.2%	32.7%	38.1%
Number and % Loyal Users/Sample	62	30	31	130	23	27	16	14	208	111
	42.7%	20.4%	30.1%	30.5%	34.3%	34.6%	18.2%	16.3%	52.8%	46.4%
Number and % Regular and Loyal Users/Sample	109	73	63	254	50	51	39	34	337	202
	75.1%	49.7%	61.2%	59.6%	74.6%	65.4%	44.3%	39.5%	85.5%	84.5%

"Loyal Users"- uses only source provider for visits. "Regular Users" - uses source provider for at least 50% of ambulatory visits.

and "regular" users there is still considerable variance for the CHC and Physician groups. One provider in each group has about 75% loyalty, as measured by both loyal and regular users, while others are lower.

Surprisingly, both hospitals exceeded all other samples in terms of degree of user loyalty, rating around 85%. This may be an effect of the very high utilization rates of the OPD users in general; when one averages nine visits to the source hospital, it is hard not to look loyal--regardless of use of other providers.

Interestingly, loyalty does not assure low cost or utilization. It would seem that having a significant group of loyal and regular users would facilitate patient management and thus promote cost effective care. The providers, however, with the most stable patient population (the OPDs) have the highest cost. The CHCs and physician providers, with patient stability averaging around 50%, have their Medicaid costs affected by other (non-source) providers. This does not seem, however, to make a large difference fiscally.

Discussion

Our forays into recent years of Medicaid recipient and claims payment data proved interesting, and certainly valuable for planning and negotiating with providers. Luckily, not having an MMIS proved less of an impossibility to data retrieval and analysis than simply a hinderance. We now know the care seeking behavior exhibited by Baltimore City recipients, and its resultant cost to the Program in total annual utilization. We know the degree of loyalty recipients exhibit towards the care sources they choose. There are important pieces of information that still need to be known, that need further research. For instance, we cannot at this point unequivocably determine the amount of the high cost associated with hospital care sources attributable to case mix severity versus practice patterns or recipient vicissitudes.

It seems safe to surmise that the cost difference between hospital OPDs and the other two major provider types (CHCs and physicians) for the AFDC subsets are not due entirely to case mix. This view is substantiated by preliminary results of a study (Community Health Center--An Initiative of Enduring Utility) by Howard Freeman and Associates at UCLA which found that inpatient utilization for patients, whose usual source of care is a CHC, is almost one half that of hospital

OPD users. A regression analysis of hospitalization rates, holding constant for the effects of age, sex, race, education, income, insurance coverage, and health status (presence or absence of a chronic condition), found significantly lower hospitalization rates for CHC users.

Some discussion has ensued with hospital providers concerning the results discussed in the previous section. Two commonly made responses concerning hospitals' tendencies could go a long way in accounting for a cost differential:

- clinic patients are usually reappointed for their next visit at their current visit; and
- clinic physicians often choose to take advantage of easily accessible diagnostic and treatment procedures rather than relying on their own best judgements.

This does not, though, adequately address the major factor accounting for higher costs: increased inpatient utilization.

Whatever the reason, the high cost of having a hospital OPD as the recipients' usual source of care is of overwhelming concern to the Program. For many years our objective was to attempt to divert recipients into more appropriate, less costly sources of care. Our data analysis, however, seems to indicate that this would be a Herculean effort, and quite possibly produce little results in terms of actual patients shifted, given their degree of loyalty. Whether it makes more sense to contract with hospitals to be case managers or to capitate them on a partial risk basis, it is crucial that they, as well as Medicaid, realize the importance of reorganizing to provide real patient management and cost effective medical care.

MICHIGAN PHYSICIAN PRIMARY SPONSOR PROGRAM

Sherry N. Wellman
Public Policy and Political Affairs
Michigan State Medical Society

Vern Smith's Introduction

We will move now to the Michigan experience. Last spring in April the legislature included in PA 35 of 1981, the FY82 appropriation act for the Michigan Department of Social Services, language directing the Department to work with the physician community to develop a plan for an alternative form of physician reimbursement. The Department requested the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgens to work with us in the development of that plan. We have benefitted from an extremely good cooperative relationship with the medical community in the development of the plan. Sherry Wellman, from the Michigan State Medical Society, has been instrumental in the development of this plan. Sherry and Bruce Hansen of the Michigan Medicaid Program have since been named co-directors of the Physician Primary Sponsor Plan as it's come to be known in Michigan.

Sherry Wellman

It's a pleasure to be here. Can I ask, outside of my friend from the Minnesota Medical Association, are there any other medical societies or medical association representatives here? You who are medicaid administrators, how many of you have a formal established meeting schedule with your state medical association? That's good, because so many times I go and speak to medical associations and they don't even know where their department of social services is, let alone who is the director. I find that very, very discouraging.

In Michigan, the Michigan State Medicaid Society has had a formal relationship with the Department of Social Services since 1972. I took on the task for being the staff person of our Medicaid Liaison Committee in 1975. The past 6 years have been—maybe there was something about 1975, that's when we had our first budget crisis and maybe it's because I took on the task, but I go around saying that I've enjoyed about as much Medicaid as I can possibly handle. I was just about ready to assign the job to someone else

on the staff when the legislature said, "Well, we've tried a lot of ideas and haven't really had a lot of success. We cut physician fees another 10% in December of 1980 and, guess what, the costs went up! It doesn't seem to work that way by just cutting the fees." So they said, "Why doesn't the Department negotiate with MSMS and MAOPS (that's the Osteopathic Society) to develop an alternative reimbursement system." That was fine, we were eager for the challenge, but we really didn't know what in the world to do. That was in May and we waited for the Department to pick up the ball and call some meetings and give us some alternatiaves that we could vote up or down. They didn't do that. They kept calling us, saying, "What kind of alternatives do you have that we can vote up or down?" We started getting a little panicky because our deadline was August 1, and it was now mid to latter part of June. We hurriedly convened a task force of the two associations--eight physicians and myself as staff. The only material we had that Bruce Hansen had provided us in May was the Safeco model, and then we got the news that they were $4 million in debt. What happened was that we eventually came up with a relatively simple idea. It's kind of interesting because we were so uninformed. I come here today and realize that there are many of you that have tried different aspects of basically what I will call a lock-in approach. One thing that is unique about our plan is that it is a total lock-in for recipients. Another feature is that the plan is based on fee-for-service. We recognize many are past the first stage of HMOs, and are into the second stage, and people are warming to IPAs, butr we were not ready to give up the fee-for-service system. However, we did suggest a case management fee, in recognition that the primary sponsor is going to have to render or authorize all medical care. The sponsor is going to have to be available 24 hours a day and provide coverage when he or she is out of town.

We recommended a case management fee of from $3 to $7. We knew $7 was going to be unrealistic, but you always negotiate for what you can. Another part of this picture that's interesting is that when the legislature mandated that there shall be negotiations, they did something very unique in my mind for state legislators—they appropriated $6.7 million in incentive fees to get whatever new program might eventually be agreed upon between the parties. What even more amazing is that in October, when we had budget cuts to the tune of $152 million allocated to the Department of Social Services, that figure held, it's still in there! Now whether it will still be in there by January 1, I don't know.

A lot of people ask me, "Why in the world did the Michigan State Medicaid Society really want to jump in and get involved?" Well there was the third paragraph to the

language of the boiler plate: The first was, "Thou shalt negotiate;" second, "There's $6.7 million;" and third, "If you all don't agree, we are going to do what we want." Now MSMS and MDSS have had a good working relationship for many years and in all honesty—when developing an alternative reimbursement plan for physicians under Medicaid—I had more confidence in the DSS than the legislature.

In August we presented our proposal, which is really quite simple: a primary sponsor under our plan can be anyone, hopefully primary care individual physicians. We left it open initially, because there are many physicians offering primary care services who aren't necessarily primary care specialists. So initially, we have said, anybody who wants to be a primary sponsor can. But we hope that most will be primary care physicians in individual and group practices. Instead of starting small, we looked to the area where most of the Medicaid funds are spent. And In Micigan, that's Wayne County. Wayne County has approximately 400,000 Medicaid eligibles. Under our program, 323,000 will be locked-in. They'll have a choice of a primary sponsor and hopefully they'll stay with the physicians they have. We estimate that maybe 50% of the recipients already have an established relationship. Many people have asked, "why isn't the physician at risk?." The asnwer is that he is if all the Medicaid patients are locked into a primary sponsor under the plan. We've got a few clinics that we already know are the "high rollers." For example, we know that there are two percent of the physicians who take out between 20-25 percent of the money. What we are going to do, and Bruce is working on this piece, is develop performance standards. We already have statistical standards on utilization; we're now going to tie those to cost. Let's say we have a clinic who initially enters the program and then can't meet the performance standards. So what? The trick is that all of those Medicaid eligibles now go to another primary sponsor. We're saying to clinic X: "We're not going to turn you over to the Board of Medicine, we're not going through a whole lengthy administrative appeals because we're not denying you your medical practice. We're just denying you access to the Medicaid market." An interesting thing that Bruce and I have found when we've been out in Wayne County and around the state marketing this plan, is that for the first time in my experience the Medicaid patient is valuable. Maybe that's because the GMENAC report predicts there's going to be a surplus of doctors very soon. Maybe it's because in Michigan physicians are not getting paid very well even by Blue Shield. The fee-for-service reimbursement is going to remain at the wonderful Medicaid rate of about 50% of what Medicare pays until savings are realized. Maybe a proposal like this can work and get started during hard times better than in the lush days—we'll see.

Our plan has a few different quirks and I'm surprised in some ways that the Department bought it. When the Department said, "OK," we kind of sat back and said, "What did we do wrong?"

When the legislature bought it, we said, "Oh, oh, we've really done something wrong." Now we find that even the recipients think it's not too bad. They worry about, "Well, I've been going to Dr. Bob for five years, are you sure he is going to sign up?" We say, well, why don't you ask him to?

What I want to leave you with from my part of our presentation is that physician involvement, medical societies—organized medicine—can do a lot, when you get the organization not only to agree with you, but give them a part of the pie of thinking up a proposal. It's a lot harder for physicians to criticize a program that they helped shape. I heard from the Ohio speaker about facing a lot of resistance from organized medicine—well, they're scared to death! If you can get them to start talking and say, "Here are some ideas, what do you think might be best?" And get their official organized support. Get a task force of doctors who are actually going to be in your target areas. Have them review the standards, have them look over those providers that are too expensive for you. Have them do a lot of the marketing. Probably the biggest commitment that MSMS has made is that we are committed to do the marketing. To that affect, we've written letters, spoken to many, many physician groups and provided the official brochure containing an application form with the MSMS, the MDSS and the MAOPS logo on it.

The challenge to design a different Medicaid Program in Michigan has been an exciting one. At this point, we're optimistic about the plans chances for success. Time will tell. It's been a pleasure being here. Thank you.

MICHIGAN PRIMARY

PHYSICIAN SPONSOR PLAN

Bruce Hansen

Director, Medicaid Policy Division
Michigan Department of Social Services

I would like to thank everyone for the opportunity to be here in New Orleans to discuss our Michigan project with you. I would particularly like to point out the work that Larry Bartlett and Rick Curtis have done. I have enjoyed my association with these two individuals, and I think they have put together a pretty good conference for us all.

As was explained by Sherry earlier, in Michigan we are putting in place in Wayne County a Primary Sponsor Plan. This plan differs somewhat from many of the plans discussed so far today. I think the critical difference is the fact that in the Michigan plan we are employing a blend between a fee-for-service concept and an HMO or risk concept. As you will see when we discuss in further detail some of the tenets of our plan, we do pay the physicians on a fee-for-service basis yet we deliver to the physician a case management fee. The risk involved to the provider is to be removed from Medicaid altogether. Another important aspect of our plan is that it requires, for all intents and purposes, all clients within Wayne County be enrolled in either this plan or in an HMO. In other words, all clients in Wayne County of which there are 323,000 will be required to choose between an HMO or a primary physician for their health care benefit. Our desire in Michigan is not to climb on a bandwagon, (I don't believe anything is a panacea), but to correct known problems within the health care sector. What we have attempted to do is identify specific problems and apply a solution. I'd like to discuss these problems with you now for a moment.

First of all, let's look at our client population. Some of the things that we will be discussing are not atypical to Michigan but you'll find them within most populations. In fact, I dare say the middle class has a number of these problems as well, but currently we can afford their excesses. There are three areas regarding the client that I would like to discuss. One is what has been termed doctor shopping and self-diagnosis. Another one is illicit traffic. The third item is inappropriate emergency room or outpatient hospital usage. To highlight each of these problems I'd like to share with you some data that I collected from our computer system for the first quarter of 1981.

Doctor Shopping:

There were 9,354 people in Wayne County that saw four or more different physicians in the referenced quarter. In fact, 88 people saw 16 or more different physicians. While some of this is certianly legitimate, the statistics speak for themselves. Self diagnosis and referral or doctor shopping is very expensive. At an average cost of $25.72 per visit for a Medicaid patient in a doctor's office, it is our estimation that by curbing these excesses we can save in Wayne County alone in excess of $2 million.

Pharmacy Traffic

I would like to note that we have had recent news articles in Wayne County that highlighted the problem of Medicaid funding illicit drug traffic. One story pointed out that a person was using a bus and hauling around welfare clients to various doctor offices and then buying their prescriptions for certain drugs. It is a very sophisticated approach, as a matter of fact, and these people know what drugs they are looking for.

Referencing the data set that I mentioned earlier in the first quarter of 1981, in Wayne County there were 21,940 people who received ten or more different prescriptions. The average cost per prescription in Michigan is $7.22. This means that by employing the plan and the lock-in feature it is our estimate that we could save approximately $3 million a year in reducing drug prescriptions for these people.

Emergency Room and Outpatient Hospital:

Finally, I would like to discuss with you the emergency room and its usage. I find that in this area particularly it seems that the problem has been blown entirely out of proportion. I've often listened to many groups discuss problems with Medicaid clients and the fact that they always show up at the emergency room for their treatment. I particularly hear this problem emphasized by physicians. The data does suggest that there are people who no doubt abuse the emergency room. For exmaple, 1,625 people went to the emergency room two or more times in the referenced quarter. Under the lock-in provision which would require that the emergency room physician gain authorization from a primary sponsor before rendering non-emergency care, much of this will be reduced. We believe that we could save in this area $1 million annually. However, it is interesting to note that out of 323,000 clients in Wayne County, only 1,625 of them visited the emergency room two or more times in that quarter. Nonetheless, it is an area that will be directly addressed under the auspices of our plan and will bring savings to the State.

All three of these areas--doctor shopping, pharmacy abuse, emergency room and outpatient hospital abuse--will be addressed through the lock-in feature of the Michigan Primary Sponsor Plan. Obviously, when people have a physician that they have access to, the usage of outpatient hospital and emergency room should go down. Additionally, the doctor shopping and self-diagnosis would be curtailed as well as the shopping for prescriptions.

I'd like now to look at the provider side of the isssue and how this plan addresses specific problems that we have historically known about in the provider sector (I'm speaking primarily of physicians). There is provider abuse in Medicaid as there is in any other population. To give you an understanding of some of this abuse let me share with you data that relates to laboratory use; specifically, laboratory services delivered within a physician's office.

In 1981 our expenditures for these in-office services approximated $17.2 million. Our data suggests that 20 physicians received in excess of 25% of the total expenditures. To put this in perspective, there are approximately 8,000 physicians in Michigan who are actively participating in the Medicaid program. Therefore, out of 8,000 physicians, 25% of an expenditure for services went to an infinitesimally small number of physicians--20 of them. Let me share with you now some specific cases:

Case I:

The total number of Medicaid patients in the quarter for this physician was 1,053.

Ninety-two percent of this physician's patients had laboratory services during a visit.

Each patient on an average received 18.35 tests.

Case II:

This physician had a total number of Medicaid patients in a quarter of 385.

Eighty-four percent of these patients had laboratory services during an office visit.

Each patient on an average received 23 tests.

You can see the magnitude of the problem. A very small number of physicians through their practice patterns are taking in an inordinately high amount of money from the Medicaid program. This creates indeed a problem because those physicians in the community, the majority of them, who are indeed treating patients appropriately have their fees cut because the availability of money is not there. Therefore, if one could purge from the program these types of individuals then more money would be available to

increase physicians' fees as well as money to put into other State funded programs. The way our plan addresses this problem is by employing a cost based standard. In other words, any physician enrolled in the plan who exceeds the 95th percentile of cost, either in total or in the categories--inpatient hospital, outpatient hospital, physician, laboratory, and pharmacy--could after review be removed from the plan.

The standards process starts with the Surveillance and Utilization Review Systems (S & UR) which is currently inplace in Michigan. Through that system we identify specific primary sponsor physicians who are abusing the Medicaid program in the various areas that I just mentioned. Within the S & UR system we are typically looking at frequency of the delivery of services. For example, the number of inpatient hospital days, the number of laboratory tests and prescriptions, the number of outpatient hospital referrals and things of this nature. This is the first point in the process of developing the 95th percentile of cost. Once the physicians have been identified within the S & UR process, statistical measures are employed to evaluate each physician's cost behavior. If the physician exceeds the 95th percentile through the application of the standards and there are no over-riding reasons to conclude error in the data set, then the physician will be disenrolled from the Michigan Primary Sponsor Program. The physician's patients will be offered a choice of another physician or an HMO.

There are some interesting observations, I believe, about this technique. In the first instance we are developing a contract with a physician. The physician must sign this contract. The standards that I just mentioned will be completely detailed. Additionally, people should be aware that the concept will be tested in the courts. It is a matter of fact when you talk of someone exceeding the 95th percentile, it is not a matter of if: we anticipate within the first six months of the plan we will have at least 45 physicians who indeed except under that rubric. I might add also that the physician community within Michigan is totally in support and agrees with this approach. It is a novel way to address removing abusive providers from the Medicaid program. It does not employ the tactic of determining appropriate medical necessity nor of proving fraud as has been historically the case. The new approach, simply stated, will explain to a physician that we simply can't afford your kind of care. Furthermore, there are other physicians who are willing to treat our clients and, therefore, it is a wise judgement on the part of the state to place those clients where better quality care can be delivered at less cost.

There is another aspect of the plan that I would like to highlight. I recall hearing earlier today Dr. Maxwell Davis from Ohio explain that in their primary network he had enrolled (I believe the number was) 6,000 ADC clients. Dr. Davis also stated that the hospital use rate for these clients was approximately 474 days per thousand eligibles. In Wayne County, Michigan, which is just a few hundred miles north of where Dr. Davis has his plan, our use rate for that same population is in excess of 1,000 days per thousand eligibles. This borders on the obscene. Under the plan we are definitely going to address hospital utilization. The standards will get at people who terribly abuse the system, but we are hoping that information and peer pressure will indeed reduce hospital utilization to reasonable levels. We know, for example, that in Wayne County our HMO's have a use rate that approximates 500 to 600 days a thousand. That is significantly better than the fee-for-service market and it's our target to gain that kind of reduction. In fact, without that type of reduction the plan cannot succeed in future years. It's going to be incumbent upon the physician community to work together through their societies and other organizations to reduce hospital usage in Wayne County. The Medicaid Program will and can provide the data which shows various use rates and various hospital costs to the physician community.

Lastly, I would like to note one other positive aspect from the State's perspective in moving into a Primary Sponsor Plan. It has to do with the fact that each client will have to choose either an HMO or a primary sponsor for their health care benefit. Presently, in Wayne County we have six HMO's with a total enrollment of 60,000 Medicaid people. We believe that since many people in the Medicaid population do not have a physician and since they will be required to select either a physician or an HMO for their health care benefit, that we will significantly increase the HMO population. In fact, we forecast almost doubling it. This alone will save the State of Michigan in the neighborhood of 5 or 6 million dollars a year.

In Michigan we have undertaken a very large endeavor. As we have all discussed primary networks I'm sure that you can see the population statistics in Wayne County in Michigan dictate that this plan is the largest primary network endeavor in the country. We're a little worried about that to be candid with you, but I think that with a little help from our friends, we'll have a good opportunity and a fair probability for success. I would like to thank you once again for the privilege and pleasure of talking with each of you and I hope that we can keep in touch within the future.

Q These savings that you intend to accrue on the outpatient clinic basis and in-patient hospital side seem to be taken out of the hides of the facilities. Is this a conscious decision, and, if so, how are you going to deal with the cost-finding problems associated with decreased utilization?

A **(Hansen)**

I don't know that this will impact hospitals significantly because it simply looks at the utilization side and that would result in a cost-shift and perhaps a unit cost increase for the hospital. I don't know that you'll have a solvency problem from this action.

Q **(Pennie Bjornstad, Idaho)**

What's your participation right now in terms of recipients to eligibles, and do you anticipate any impact from people who perhaps weren't getting medical care, but once you've sent them a letter and asked them to sign up for somebody, decide maybe that's a good idea?

A **(Hansen)**

An alarmingly frightening question. That is something that really has to be handled carefully. When the idea of the case management fee first arrived, the medical community wanted to do it that way. Not for any clandestine reason. They were saying, "We don't want to get paid for not delivering a service. We've been in the fee-for-service marketplace for a long time." We discussed it. We said we couldn't do that because then I'm going to pay this horribly low $11.50 for the office fee, but I'm going to pay it for 323,00 folks, and the bank just broke. We haven't really developed the language for communicating with the client right now. We're meeting with a lot of client groups. That's a very delicate piece. We're trying to word that in such a manner that we don't precipitate exactly what you are talking about. But I don't have the right answer for you right now.

Q **(Maxwell Davis)**

How many HMOs are there in Michigan at the present time?

A **(Smith)**

There are eight.

Q **(Davis)**

I understand that the Michigan Blue Cross is going to have 8 or 10 HMOs of their own over the next 12 to 18 months. How many of these accept Medicaid patients or are under contract to the state?

A **(Smith)**

There is one right now.

Q **(Davis)**

What effort are you making to get the other HMOs involved in taking Medicaid patients in the State of Michigan.

A **(Hansen)**

About as great an effort as we can. We do have a problem with what we're willing to pay and what they would like.

A **(Paul Allen, Michigan)**

I would like to make a point that we have 63,000 Medicaid clients enrolled in HMOs right now. That's 6.3% of our population. Twenty-two percent of the ADC population in Detroit is in an HMO. That's an enviable record, and they're saving money. If we could double that: if there 126,000, through the emphasis on this primary care network as a first choice, then we've paid for this program, even if this part of it doesn't work.

A **(Wellman)**

One of the interesting things we've found in meeting with the HMOs was that they got very worried. And even though we say recipients will have a choice, they are worried that individual physicians or groups of physicians are going to embark upon a marketing campaigns very similar to what the Michigan State Medicaid Society feared would happen when HMOs started up. For example, they said, "Are you going to allow them to advertise?" And we said, do you? And they said, "Well, we don't mind competition, but be fair. You're getting physicians $3 a month for not doing anything." I got a little cynical and asked, "What about all that federal seed money you got that physicians objected to?"

Q **(Beatrice)**

Can the recipient who picks a primary physician go to an OPD?

A **(Wellman)**

Not unless it's authorized.

Q **(Beatrice)**

Why would a physician authorize an OPD visit?

A **(Wellman)**

We hope he won't.

Q **(Beatrice)**

Then why are you projecting a 25% percent reduction rather than a 98%?

A **(Hansen)**

Because there are number of procedures that are performed in out-patient hospital that will still be performed in out-patient hospital, such as out-patient surgeries. In Michigan we have what we would call a group practice. We don't have a lot of free-standing surgical centers and such things as that. So outpatient hospital is still going to be a very viable entity for rendering that kind of care.

Q **(Beatrice)**

It strikes me that the question asked earlier about which hospitals are going to close out, it sounds like the impact will be greater than a 25% impact. We tried to do something like this. You have the same kind of large hospital density in that area as we have in Boston and it's amazing to me that you can get a plan like that through what must be really rabid hospital opposition.

A **(Hansen)**

The rabid hasn't happened yet. We've been fairly conservative in our estimates, that's first of all. I would agree with you--there's probably much more savings there but I would much rather be on the low side than on the high side. Regarding your other question, it's the physician community support that has been so terrific in doing this thing and somehow curtailing the political opposition that one may have. In fact, many of the hospitals are wanting to be primary sponsors in our plan. That is a whole host of other problems that we are now attempting to address.

Q **(Tom Russo, New Jersey)**

Did you receive federal waiver approval for this project yet?

A **(Smith)**

No, the letter requesting federal approval has been sent. We have not heard, but in the spirit of the new federalism, we expect a positive response.

A **(Hansen)**

In that great spirit I spoke recently with the Region V federal folks. The waiver request has gone to central office. It is highly approvable. It is now at the Region V office. There are a few peculiar things that they're working on--nothing of major consequence. I think that there is a very, very high probability that we'll see success in that shortly.

Q **(Russo)**

I hope you have more luck than New Jersey. We submitted a federal waiver request about eight months ago, very similar to this one, to lock-in the Medicaid patient to a single physician and a single pharmacist for case management purposes, mandating it in two counties. We had the endorsement of the New Jersey Hospital Association,

the New Jersey Medical Society, the New Jersey Pharmacy Association. We still have not received approval on that.

A **(Curtis)**

If you submitted it as an 1115 waiver request, you might consider resubmitting it under the freedom of choice provision of the 1981 Reconciliation Act.

A **(Smith)**

I think Rick's suggestion is a good one. Given the changes in the environment that have taken place over the summer, it may be well to resubmit it under the new rules.

Q **(Bjornstad)**

We had a state plan amendment pending and the ruling was that they had to act on that within 90 days from August 15 or it was considered approved. I would consider it approved.

A **(Smith)**

That's only under the new reconciliation act. Rick's point is that the 90 days applies to state plan requests, not to 1115s.

Q **(Alan Wheeler, New Jersey)**

Do you have a handle of whether you have the physicians necessary to serve your 300,000 recipients in Wayne County or are they going to have to relocate there? Are they going to do that for the three dollars?

A **(Wellman)**

Our President sent out a letter just to MSMS members in Wayne County and we got so many responses back it's difficult to tally them. I asked for an indication of their current Medicaid case load. The next line said, " I would willing to accept new Medicaid cases about..." A poorly worded question, because I got answers back saying, "Now, unlimited, question mark." I also used a single reply card and I got cards back from individual physicians, cards back with one name on it, saying they would be willing to take 3,000 as an outpatient hospital. Hopefully, the brochure application designed by DSS will be better--at least the form will be more accurate. What we're doing is taking all of these and just using a zip code map and putting pins in it, seeing what kind of penetration we've got. And then if we don't have it in the Down River Area, for example, we'll have to do more marketing to specific tarket geographic areas.

A **(Smith)**

Sherry has indicated to me that there were about 300 cards received. Of those 300, there was only one that could be characterized as a negative response, is that correct? There is in fact a very positive acceptance in the Wayne County area.

A **(Hansen)**

Just want to note to you that in Wayne there are about 3700 physicians. You might then suggest that maybe 2200 of them or 2000 would be primary care. We are not going to implement this plan unless we have the cooperation of the physician community to address the needs of the client specified. We will and are now sending out this application. We will be looking at where the physicians are located in light of where our population is located, and as Sherry mentioned, trying to, if necessary, go at remarketing. There are about 1200 physicians in that particular area that currently do not accept Medicaid. They are a primary target for this particular initiative, and we're hoping that we can bring some significant number of those physicians back into Medicaid roles.

A **(Wellman)**

One more think on that. We found from our replies that we have several physicians who are just across the border in either Oakland or Macomb who have substantial Medicaid case loads. So what we've done in those areas is say, "No, you don't have to move into Wayne County, doctor, because it's the patients and where they are that we are concerned about." So there will be some crossover in terms of where the doctors area.

Q **(Spitz)**

In terms of dealing with the problem of enrolling people that aren't using medical services and having them use them, would it be possible to stagger the enrollment, so that you only send out notifications to individuals to have used physician services in the last three or six months and then as individuals go out to use services, then they are enrolled rather than enrolling the entire population?

The question is, "Is it possible to stagger enrollment so that you hit the high utilizers first?"

A **(Hansen)**

We're going to attempt to use our data processing system to identify those patient-physician relationships that already exist to then match the client with the physician--those will be the people who use the service within a six months period. We will then contact the clients, suggesting that our information points out that this is their physician. If that's OK, then fine we enroll them. In the residual population we are hoping to identify the high user client and to take advantage of our intake process for redetermination of eligibility, and at that particular point explain to the client his choice. We are thinking along those lines, and just hope we can do it.

CONFERENCE SUMMARY

Vernon Smith, PhD
Director, Bureau of Medicaid Policy and Information
Michigan Department of Social Services

We all came together today with some high expectations, and I think those expectations have perhaps been exceeded. We began this morning with Rick Curtis describing the legislative history of the Omnibus Budget Reconciliation Act of 1981, PL 97-35, which provided states the legal base on which to embark on the kinds of primary care plans we've been discussing today.

Bruce Spitz very succinctly summarized the paper which had been provided to us prior to the conference. Most importantly, Bruce described what a primary care network is. Specifically, it first consists of a primary care physician or physicians in the community in solo or group practice. Secondly, patients are enrolled and matched to a physician and, thirdly, there are control mechanisms over the total medical care of the patient assigned to a primary care physician. The key is that the primary physician is the gate keeper, and we've heard that phrase over and over today. The reimbursement system may be either fee-for-service or capitation.

In the first panel, Roswell Bond described the Safeco experience. This was particularly enlightening to us because Safeco has been held up as the model in this area for a number of years, at least for those of us who have studied the issue from afar. It was particularly interesting to me to hear Ros describe the features of the plan and the three basic reasons described as contributing to the apparent "failure" which led to its recent reorganization and regeneration. First he indicated that they didn't stay home a lot; they traveled because of the national recognition that was afforded. Secondly, they have perceived that the communication with physicians was not completely proper or to the right extent and there is in fact a need to show physicians what they are doing right or wrong: reinforcement and feedback is essential. Thirdly, on data accumulation and analysis, there was a finding that there was difficulty in assessing performance because of lack of access to data. Once those data were accessed, a number of important conclusions were arrived at, including that the benefit was too liberal, and that there had

been a loss of control over specialty care, specifically, the primary care physicians could not or were not controlling specialists. And this point was particularly found to be essential as he illustrasted in his chart that 80% of the cost of care was associated with referral or specialist care. Finally, he found that there were too many primary care physicians. All physicians who say they are primary care are not, in his judgement.

In concluding Ros identified a very important factor in control, and that is if you are going to control Medicaid cost, you have to control the factors of Health Care production. In this case we're talking about those expenditures which are in fact controlled by physicians.

Wisconsin Physician Services Plan was summarized and described by Dr. Paul Simenstad. In describing why this plan has been successful over the past ten years, he identified that the physicians are at risk; that self-referrals are avoided; that there is high physician participation--as many as 95% participate and cooperate in the plan; and finally that the plan was imposed on the existing health care system. There was no need to create new institutions or destroy those that were already there.

The Group Health Plan of Northeast Ohio was described by Dr. Maxwell Davis. The success of this plan again was ascribed to the role of the primary care physician as the gate keeper. In the case of the Group Health Plan of Northeast Ohio, there is a very direct mechanism for the primary care physician to control specialists in referral care, ie, the primary care physician actually issues the checks for that referral care. It has also a mechanism for sharing risks for hospital cost, and mechanisms for assessing the quality of care. And there is an excellent data system which they are able to use.

Dr. Frank Evans described the Middle Georgia Medical Care Insurance Plan. This plan is particularly fascinating to me because the premium depends on the physician selected by the patient and the premium varies according to the cost experience associated with care provided by that physician. Three accounts were used: a deductible account, a physician group account and a general fund. It's a fairly complex system to comprehend, at least at my first impression, but I'm sure that once it's used perhaps the physicians will begin to understand it. It will be very interesting to see how this proposal works out.

This afternoon Dr. John Abramson and Dr. David Schmidt further described the Group Health Plan of Northeast Ohio. Again, it was emphasized that the physician is firmly in the gate keeper role. The primary care physician actually writes the check and that does give him control over specialty care, self-referral to specialists, and non-emergency services provided in emergency room. The result has been that physician reimbursement is 111% of the fee-for-service counterpart: the physicians are paid more but the overall system is actually saving money. This is due to a significant degree to the difference in hospital days per thousand, being approximately 40% of that which is experienced among other AFDC recipients in the State of Ohio.

Becky Belangy described Multicare in Multnomah County, Oregon. This is a case management system using a fee-for-service approach which provides services to the medically indigent population. Lessons were listed from the six years of experience of this plan. Specifically, that the broker model was a successful approach. Costs were less, at least in part, because co-pays were accepted as long as they were reasonable. They did find that adverse selection was a major barrier to integrating the medically needy into pre-paid plans, and that the open panel plans were more succeptable to adverse selection.

A health status appraisal approach was described as a unique mechanism to sort clients who were high risk or who were not high risk. Again, the success of the plan was attributable to the responsibility of the primary care physician for authorization of referrals, approval of billings for referral and hospital billings, and assuring quality care.

Dennis Beatrice described the experience of the State of Massachusetts Medicaid Program and its "managed plans of care". Advantages were listed for the case management approach used in Massachusetts for the five cites still in operation. A number of problems were identified. Medicaid programs can benefit from experience here. Out-of-plan utilization was not controlled. Cost couldn't be tracked because the data system was inadequate. The provider risk was too limited. The elderly and the disabled population was not included.

Finally, we have heard from two states with primary care network initiatives. Lyda Sanford described the Maryland project, while Sherry Wellman and Bruce Hansen described the ambitious Michigan Medicaid project known as the Physician Primary Sponsor Plan.

I would like to summarize briefly the lessons that we have learned as Medicaid administrators which we should keep in mind if we wish to pursue primary care networks within our states. I'd be interested in anything those of you who have participated as presentors or in the audience would care to add to what I've summarized in the following seven points:

1. Close physician cooperation is necessary.

2. It is important to carefully select physicians who will be participating.

3. The plan must involve some kind of risk. The Group Health Plan of Northeast Ohio and the Georgia Plan have come up with two different ways of addressing this. This element is required in order to control for self-referral to specialists and to emergency room.

4. Feedback to the physician participants is essential. The score keeping term was used. Awareness of the economic consequences of physician decisions must be heightened. Communicating the standards of performance and the performance of individual physicians against those standards is essential if the physicians are to know how there are doing.

5. As a practical matter, it's been suggested that a plan start small. This is advice not taken by Michigan. States should go ahead and take the risk, implement a plan, even though it may well be imperfect. If it's good, it's good enough.

6. Mandatory enrollment rather than voluntary has been identified as a source of success.

7. For maximum fiscal impact--given the disproportionate share of expenditures that are associated with long-term care and with the elderly and the disabled--it would be important to include the elderly and disabled, the SSI population, in the plan.

Finally, I would like to conclude by offering the following observation. As we arrived for this one-day conference we had with us a draft copy of what was then the definitive work on primary care networks--the pre-conference draft of Bruce Spitz' paper. We have witnessed today presentation from those in the country who are at the forefront

of development of primary care networks. This combination of presentations has in a synergistic sort of way, added to the synthesis of information which Bruce Spitz had prepared prior to the conference. Those in this room had made available to us, and we have acquired, a body of concepts and experiences which has never before been brought together at one place and time.

On this day perhaps it could be said that the cutting edge of development of primary care networks has been in this room and has been significantly advanced. Perhaps more importantly for those of us working in Medicaid programs the timing of this event has provided insight into an opportunity which was only recently provided through a change in federal law, a scant three-and-half months ago. To the extent this information is shared in our own states and acted upon, this one day conference may in years to come be cited for its catalytic role in reshaping the health care delivery system in this country toward one which is more efficient, more effective, with appropriate controls and incentives and at lower cost for patients themselves and society at large.

For this important conference, we are indebted to the National Governors' Association, and in particular to Rick Curtis and Larry Bartlett.

National Governors' Association
HALL OF THE STATES
444 North Capitol Street • Washington, D.C. 20001

CONFERENCE ON MEDICAID AND PRIMARY CARE NETWORKS/CASE MANAGEMENT SYSTEMS

Wednesday, December 2, 1981
International Hotel
New Orleans, Louisiana

AGENDA

9:00 am **Welcome**

Background

- Richard Curtis
  Associate Staff Director for Health Policy
  National Governors' Association

Conceptual Overview: Primary Care Networks — What Are They?

- Bruce Spitz
  NGA Consultant, and
  Director, Medicaid Consulting Consortium

9:45 am **Coffee Break**

10:00 am **Private Sector Experience with Primary Care Networks (PCNs)**

Presentations by representatives from organizations which have operated health care delivery and reimbursement systems based upon the PCN or physician specialty referral model.

Safeco's United Healthcare

- Roswell Bond
  Former Chairman of the Board
  United Healthcare, and
  President, Safeco Life Insurance Company;
  Currently President, Healthnet Management

Wisconsin Physician Services

- Paul O. Simenstad, M.D.
  Medical Director, Wisconsin Physicians Service

This conference is supported through a grant from the
Office of Research, Demonstrations, and Statistics
Health Care Financing Administration
Department of Health and Human Services

Group Health of Northeast Ohio

- Maxwell Davis, D.D.S.
  Executive Director, Group Health Plan of Northeast Ohio

Middle Georgia Medicalcare

- Frank Evans, M.D.
  Vice-President, Middle Georgia Medicalcare

Moderator: Lawrence Bartlett
Coordinator, NGA's State Medicaid
Program Information Center

Noon **Lunch**

1:00 pm **The Experience of Primary Care Networks Serving an Indigent Population**

Presentations will be made by representatives of organizations which have set up primary care network/case management systems to provide care to Medicaid and/or non-Medicaid indigent populations.

Group Health of Northeast Ohio

- David Schmidt, M.D.
  Director, Department of Family Medicine
  University Hospitals of Cleveland

and

- John Abramson, M.D.
  Department of Family Medicine
  University Hospitals of Cleveland

Multicare of Multnomah County, Oregon

- Becky Belangy
  Director, Project Health
  Multnomah County, Oregon

Massachusetts Medicaid Case Management Program

- Dennis Beatrice
  Assistant Commissioner for Medical Services
  Massachusetts Department of Public Welfare

Moderator: Barbara Matula
Director, Division of Medical Assistance
North Carolina Department of Human Resources

3:00 pm **What States Are Doing to Implement Primary Care Networks**

Maryland

- Lyda Sanford
  Chief, Division of Program Development
  Maryland Department of Health and Hygiene

Michigan

- Bruce Hansan
  Director, Medicaid Policy Division
  Michigan Department of Social Services

and

- Sherry N. Wellman
  Public Policy and Political Affairs
  Michigan State Medical Society

Moderator: Vernon K. Smith, Ph.D.
Director, Bureau of Medicaid Policy and Information
Michigan Department of Social Services

4:45 pm **Summary Remarks** – Vernon Smith

4:55 pm **Conference Wrap-Up** – Lawrence Bartlett

5:00 p.m **Adjourn**

SPECIAL ARTICLE

PHYSICIAN-BASED GROUP INSURANCE

A Proposal for Medical Cost Control

FRANK O. EVANS, JR., M.D.

IN our system of health care, individual doctors direct most medical expenditures, whereas administrators try to control costs through persuasion or regulation. This system predictably wastes money and time in conflicts between physicians and administrators. If those responsible for cost control do not interfere with the care of patients, physicians tend to overspend. On the other hand, the quality of medical care is threatened when administrators can modify the medical decisions of physicians.

This paper is a proposal for controlling medical costs that does not depend on detailed regulatory control. In developing this plan, which I call "Physician-Based Group Insurance" (PBGI), I have made four assumptions. First of all, primary physicians are the key to controlling costs, because of their unique position as general managers of their patients' health care — a position analogous to that of general contractors in the building trades. In most cases, the primary physician either determines the medical services that the patient will receive or chooses the consultant who does. Secondly, the primary physician is in the best position to evaluate the quality of consultants, laboratories, and hospitals. Thirdly, it is less expensive and probably more accurate to judge physicians according to their overall performance or average cost per patient than to judge each medical decision separately. Fourthly, the best person to balance the quality of medicine against its cost is the patient. Whatever patients lack in technical expertise they make up with firsthand knowledge of their physicians' compassion, availability, thoroughness, reputation, and therapeutic effectiveness. Our health-insurance system could be modified to reflect these conditions if a patient's insurance premium were made a function of the cost of his or her physician's style of medicine.

PHYSICIAN-BASED GROUP INSURANCE

When a business owner obtains group medical insurance for employees, the insurance company estimates the risk and sets the premium accordingly. This premium may subsequently be altered depending on the experience of the group. Under the proposed PBGI, a physician sponsors a similar group insurance policy on behalf of his or her patients. The cost of the physician's style of medicine then becomes a major factor in the insurance company's estimate of the proper premium. Since the fees for hospitalizations, laboratory work, and consultations will be paid through this group policy, the insurance premium will reflect not only the thriftiness of the primary physician, but also the cost effectiveness of that physician's consultants, hospital, and diagnostic facilities.

In brief, here is the way in which the PBGI plan might work. The primary-care physician chooses an insurance company for his or her patients. The patient selects a physician and pays the premium to that physician's insurance company. To be covered by the insurance, the patient must obtain all primary care from that physician and must be referred by that physician to receive any other nonemergency care, including specialty, hospital, and laboratory services. Patients can change primary-care physicians whenever they wish, and physicians can change their contracts with insurance companies if they do not like the premiums, coverage, or service.

Like conventional health-insurance plans, PBGI policies might take many forms, but the details would have to satisfy the insurance company, the physician, and the patients. PBGI policies should contain equitable rules for changing physicians. For example, the policy might convert to traditional insurance with less coverage if the patient changed doctors. Variation in the premium rates depending on age and sex would ensure rates competitive with more conventional insurance, and some out-of-pocket payments by the patient might discourage overusage. If the insurance company agreed, a physician could theoretically be paid in any way he or she liked, including fee-for-service, capitation, or salary. If, however, the payment scheme was administratively expensive or resulted in an unpredictable risk for the insurance company, the physician could expect the company to set a higher premium for patients. Conversely, cooperation between the physician and insurance company might result in lower premiums. For example, the primary physician might agree to make fee-schedule changes annually and furnish these changes to the insurance company in advance. The insurance company could then use this data to project more accurately the claims of that physician's patients.

If several companies offered PBGI and competition limited their overhead and profits, then the premium rate would be determined largely by the only other important expense — the projected claims. If the company's estimate of the claims was too high, another company might be willing to write the policy for less.

From Baldwin County Hospital, Milledgeville, Ga. (address reprint requests to Dr. Evans at 511 N. Cobb St., Milledgeville, GA 31061).

Reprinted from the *New England Journal of Medicine*
302:1280-1283 (June 5), 1980

If the estimate was too low, the company would lose money. The insurance company would, therefore, furnish reserves and estimate risk, but the physician would control the premium through his or her style of medicine.

It should be advantageous to extend the PBGI concept to groups of physicians, since small-group practice is more cost efficient than solo practice. Such an extended PBGI policy might be considered a health-maintenance organization small enough for each physician to have an obvious impact on the premium. As the group size increases, however, the incentive for cost control will probably decrease sharply. Ultimately, competition should determine the ideal group size, and physicians who wished to practice in a group whose size differed from the ideal would probably have to accept lower incomes.

There are several reasons for believing that primary-care physicians will control costs if they participate in a PBGI plan. First of all, most physicians are competitive. A physician-related premium that is public knowledge should challenge the physician to control costs as a matter of pride. Secondly, most physicians do not know the costs of hospital services or the charges of their consultants. Primary-care physicians would learn these costs since they would approve the consultant and hospital claims. Thirdly, PBGI would permit and reward innovation. For example, if a primary physician developed methods of home health care, these methods could be covered by the PBGI policy. If the methods resulted in less hospitalization, a lower premium might result. Our present system discourages innovation since insurance companies cannot make exceptions in their coverage for individual physicians. Fourthly, physicians with high premiums might lose their patients for purely economic reasons (the law of supply and demand). Conversely, physicians with low premiums would have the satisfaction of saving their patients' money and would be rewarded by the patients' gratitude. Furthermore, PBGI would decrease duplication of services since all of a patient's medical care would be obtained through (but not from) a single physician. Finally, if physicians reduced waste and chose to increase their own fees, they could increase their incomes without increasing the premiums to their patients. A similar mechanism works in industry — the money saved by a more efficient manufacturing process can either be passed on to the consumer or kept as higher profits for the manufacturer. These higher profits are minimized by competition but serve as a reward for innovation.

Subsidies for Referral and Catastrophic Illness

With unmodified PBGI, it would be to the physician's advantage to care for relatively healthy patients. Relatively sick patients might have difficulty obtaining care, and the physicians who cared for them would be financially penalized. As an example, assume that a physician has 100 PBGI patients whose claims average $400 per patient per year. If we exclude administrative costs and insurance-company profits, each patient's premium should be about $400 per year. If this physician accepted an additional patient with a $40,000 hospitalization, the premium that each of his or her patients paid would increase to about $800 per year.

Unmodified PBGI should strongly encourage cost control but could also result in underuse of secondary and tertiary care, loss of quality, and a selection bias against sicker patients. This is, in a sense, the antithesis of the fee-for-service system with third-party insurance, which encourages hospital medicine, favors relatively sick patients, and makes overuse financially advantageous.

The ideal system should be between these two extremes. Since no one can predict the amount of economic pressure needed to induce physicians to be thrifty without jeopardizing quality, the system should be adjustable so that it can be tuned empirically to balance the tendency to overusage and sick-patient care against the tendency to underusage and well-patient care. We could create such a system by using PBGI as the basic method of cost control and modifying it by subsidizing the claims of expensive patients so that their impact would be blunted but not eliminated. An example of such a subsidy schedule is given in Table 1. Physicians who took care of more than their share of very sick patients would be compensated by additional income from these patients but would be indirectly penalized by an increase in their patients' premium rate. The impact of an expensive patient on the physician's premium rate would depend on the catastrophic-illness subsidy. The greater the subsidy, the smaller the increase in premium. The system could actually be modified continuously from pure PBGI (subsidy = 0) to pure fee-for-service with third-party insurance and no cost controls (subsidy = 100 per cent).

The tendency for unsubsidized PBGI to discourage referrals and hospitalization could be adjusted by means of subsidies for claims generated by consultants, hospitals, and diagnostic facilities so that primary physicians would be penalized somewhat for these claims but less than for their own claims. Other subsidies could be created if the need arose.

The subsidies might be paid from a subsidy account funded through the addition of a fixed amount to the

Table 1. Subsidy Schedule for Catastrophic Illness.

Patient's Annual Medical Claims ($)	Subsidy ($)
0 - 500	0
500 - 2,500	50% of amount > 500
2,500 - 5,500	1,000 + 75% of amount > 2,500
5,000 - 10,000	2,875 + 90% of amount > 5,000
> 10,000	7,375 + 95% of amount > 10,000

premiums of all PBGI policies. The PBGI premium would thus be the sum of a variable part dependent on the individual physician's expenditures and a fixed part that would go into the subsidy account. The relative importance of these parts would depend on the way in which subsidies are set. According to the example given in Table 1, if a patient's total medical claims amounted to $5000 for the year, the catastrophic-illness subsidy would be $2875 and would be paid from the subsidy account; it would not directly affect the individual physician's PBGI premium. The remaining $2125 would come from the variable part of the premium and would ultimately be paid by the primary physician's own patients.

At first, individual insurance companies might set their own subsidy schedules. Ultimately, competition will force the insurance companies to alter their subsidies to maximize profits, which might not be best for the patients. This conflict of interest could be avoided if the subsidy schedules and fixed premium were established for all insurance companies by an independent organization with the responsibility of managing a common subsidy account. Although this organization might be a government agency, it might also be established through the voluntary cooperation of the insurance companies involved. If such organizations were established by states or regions, each could profit from the others' experience.

PBGI should be introduced with a relatively large fixed premium and subsidies because they would not be a real departure from our present insurance system. Companies could then alter the subsidies to encourage economy by making the patients' premiums more dependent on the cost effectiveness of the primary physician.

The financing of research, medical teaching, renal dialysis, and other special problems is beyond the scope of this paper. PBGI would, of course, not preclude more traditional methods of compensation in such areas.

Discussion

PBGI is similar to the SAFECO[1] plan currently in operation in California and Washington. SAFECO and PBGI both use financial incentives to influence medical expenditures, recognize the central role of the primary-care physician, and have provision for catastrophic illness. Using these principles, SAFECO has brought about a considerable reduction in hospitalization for its beneficiaries. SAFECO and PBGI differ, however, in several ways. First of all, the financial incentives are different. SAFECO encourages thrift by returning part of the savings to the primary-care physician, whereas PBGI uses competition between physicians to encourage cost control and passes any savings directly to the patient. Secondly, SAFECO does not have a subsidy to encourage secondary and tertiary care. Thirdly, SAFECO is less complex than PBGI. This lesser complexity is an advantage for SAFECO since physician understanding is critical. Wisconsin Physicians Service and several other plans also use incentives similar to SAFECO and PBGI.

If PBGI is to have an impact on the cost of health care, enough physicians in a particular area must be involved to assure competition. At the same time, enough patients must be able to select PBGI so that it will be worthwhile for primary physicians to work out the administrative details and modify their styles of practice. Few Americans are now in a position to substitute PBGI for their current insurance plans, because most of them are insured through the government or large private groups that do not permit individual members to choose the insurance that they prefer. Recently, however, Enthoven suggested a method of altering the tax structure and subsidizing the poor that would place the buying power for health insurance in the hands of individual consumers.[2] If such a plan were adopted, PBGI could become a competitor in the health-care market.

PBGI shifts the responsibility for cost control from the insurance company to the primary-care physician and unifies in the physician the accountability for both cost and quality. I think that, given the choice, most physicians prefer the challenge of becoming cost effective on their own to loss of their professional freedom in a government bureaucracy. Medicine could become more economical if physicians were not penalized for being thrifty.[3] PBGI would reward both quality and cost effectiveness while leaving the details of caring for patients to the physician.

With PBGI, each patient could select his or her own physician on the basis of reputation and cost. Patients' satisfaction would be a major factor in a primary physician's financial success, and the insurance policy would be a formal acknowledgment of the physician's responsibility to the patient. Disagreement over money between patient and physician would be reduced since patients would pay their insurance premiums in advance. For all these reasons, PBGI should strengthen the relation between physician and patient.

With PBGI, insurance companies would continue to serve the public by appraising risk and furnishing the necessary reserves for insurance, but they would no longer have the responsibility for controlling medical costs. Since each physician would have only one insurance company and since detailed review of insurance claims would not be necessary, the processing of insurance claims could be streamlined. The primary physician would have the task of approving the claims of hospitals and consultants but in most instances would already know enough about the case so that a detailed review of the claims would be unnecessary. Since PBGI would be prepaid, collection expenses and bad debts would be eliminated.

Finally, many physicians oppose government financing of health care because they fear arbitrary reg-

imentation and inflexible guidelines for the treatment of patients. If PBGI policies are developed that permit physician independence and adequately balance cost against quality, then a national health-insurance plan acceptable to patients, physicians, and political leaders might result.

I am indebted to Dr. Mark Coleman, Dr. A. C. Enthoven, Dr. Samuel Goodrich, Dr. Luis Samper, Dr. Edwin Evans, Dr. J. G. Bohorfoush, and Dr. R. E. Evans for their helpful criticisms and suggestions.

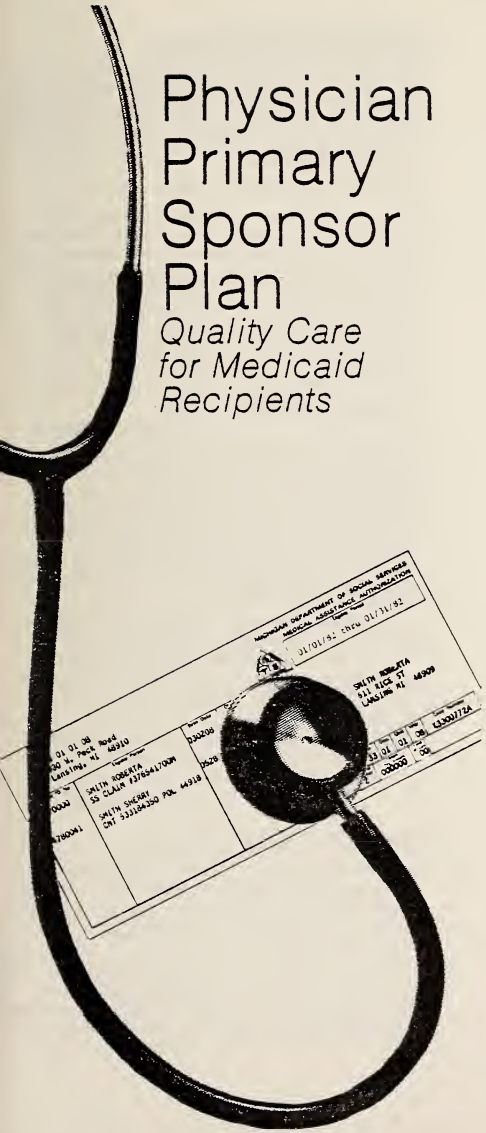
References

1. Moore S. Cost containment through risk-sharing by primary-care physicians. N Engl J Med. 1979; 300:1359-62.
2. Enthoven AC. Consumer-choice health plan. N Engl J Med. 1978; 298:650-8, 709-20.
3. *Idem.* Shattuck Lecture — Cutting cost without cutting the quality of care. N Engl J Med. 1978; 298:1229-38.

©Copyright, 1980, by the Massachusetts Medical Society
Printed in the U.S.A.

Physician Primary Sponsor Plan

Quality Care for Medicaid Recipients



PURPOSE

The Physician Primary Sponsor Plan was developed by the Michigan State Medical Society (MSMS) and the Michigan Association of Osteopathic Physicians and Surgeons (MAOP&S) in conjunction with the Michigan Department of Social Services (MDSS) in response to Public Act 35 of 1981. The Plan was developed to:

- increase physician participation,
- provide recipient access to mainstream medical care,
- better manage recipient use of medical services, and
- contain costs in Medicaid while paying equable fees to physicians.

Under the Plan, the recipient's medical care will be authorized or arranged for by a primary sponsor, thus guaranteeing the physician/patient relationship.

PRIMARY SPONSOR

Generally, a primary sponsor will be a physician whose practice is in the field of general practice, family practice, pediatrics, internal medicine, or obstetrics/gynecology. When a physician who has a practice specialty becomes a primary sponsor, he or she must render primary care to the Medicaid recipient. The physician may have an individual practice or be in a group practice, a clinic practice or an outpatient hospital practice which has agreed to be reimbursed on a fee-for-service basis.

The setting must be one which has control of the recipient's medical chart. For example, when physicians in a clinic setting are primary sponsors, a recipient may request services and be seen by alternate physicians, but the chart and billing would serve to indicate whether duplicate or unnecessary services would result.

If a physician wishing to be a primary sponsor is not currently a participating Medicaid provider, he or she would also have to enroll in the Medicaid program.

ELIGIBLE MEDICAID RECIPIENT

Most Medicaid recipients qualify for the Plan. A recipient will *NOT* be assigned a primary sponsor if he or she is currently:

- residing in a long-term-care facility,
- enrolled in a health maintenance organization (HMO),
- a Group II recipient with an end date of Medicaid eligibility (e.g., the recipient will be eligible for Medicaid for a short time due to a major illness), or
- eligible for Medicare (i.e., a Title XVIII/XIX recipient).

The Physician Primary Sponsor Plan *does not* apply to the Crippled Children, General Assistance (GA) Medical or Resident County Hospitalization (RCH) Programs.

The recipients excluded from the Plan will continue to receive Medicaid-covered services from the providers they choose. As a primary sponsor, you may also continue to provide services to these recipients according to the guidelines in the Medical Assistance Program Manual.

SPONSOR-RECIPIENT MATCH

If you are already participating in the Medicaid program and sign an agreement to become a primary sponsor, the MDSS will generate a list of all the Medicaid recipients that you have seen in the last six months. If you are identified as a recipient's primary physician during this time frame, the recipient will be assigned to you for continued primary care. The MDSS will send the recipient a letter explaining the Plan and indicating that you have been assigned as his or her primary sponsor. The recipient will be given a telephone number to call to:

- ask questions about the Physician Primary Sponsor Plan,
- add other family members to your care that were not identified as having received services in the six-month time frame, or
- change to another primary sponsor.

You will be notified *prior* to the effective date of the assignment which recipients are under your medical management. In addition to receiving the notification letter from MDSS, the recipient will be identified on the Medicaid ID Card as having a primary sponsor. Your name and telephone number may also be printed on the Medicaid ID Card as the recipient's primary sponsor.

If a recipient is eligible for a primary sponsor but was not initially identified as previously explained, the local caseworker will present the following options to the recipient at his or her eligibility redetermination:

- The recipient may continue with his or her current physician, if the physician is participating in the Plan.
- The recipient may choose a physician from a list of physicians participating in the Plan. NOTE: Your name will be placed on the list if you indicate on the application that you are willing to be assigned additional Medicaid recipients under the Plan. If you currently do not have any Medicaid recipients you must indicate on the application that you will accept new Medicaid recipients in order for your name to be placed on the primary sponsor list.
- The recipient may enroll in an HMO, in which case all family members must enroll in the HMO.

NOTE: Except for HMO recipients, family members may choose the same primary sponsor or choose different primary sponsors (e.g., a pediatrician for a child and a different physician for the adults in the family).

When a person first becomes eligible for Medicaid, and he or she is also eligible for the Plan, the local caseworker will present the three options discussed above.

CHANGING AN ASSIGNMENT

Either you or a recipient wishing to terminate your individual sponsor-recipient relationship may do so upon reasonable notice and for a justifiable cause. You will be instructed who to contact to initiate such action. When a recipient is removed from one primary sponsor he or she must select another.

PROVIDING MEDICAL CARE

As a primary sponsor, you continue to provide and arrange Medicaid-covered services, except vision and dental, for the recipients under your care. You prescribe treatment (e.g., prescriptions, laboratory and radiology tests, medical equipment, hospitalization) whenever medically necessary. You must be available or have appropriate coverage for your Medicaid recipients on a 24-hour basis. There are no additional Medicaid program requirements for the care you provide as a primary sponsor.

REFERRING MEDICAL CARE

You may continue to refer the recipient to another physician for specialty care. The physician to whom the recipient has been referred can order laboratory and radiology tests, and prescriptions without your authorization; however, you must be notified when the recipient is admitted into the hospital. The sponsor will authorize the referral care for the duration of the recipient's illness. If the recipient has a chronic condition which requires ongoing specialty care, the authorization will cover a longer period.

You will be informed by the MDSS of all the services which were provided to the recipient, including those services which were provided as a result of the referral. This report will serve as an informational/educational vehicle for you to further evaluate the services received by the recipient.

NOTE: A specialist who is not a primary sponsor will continue to treat Medicaid recipients who are referred from their primary sponsors or are excluded from the Physician Primary Sponsor Plan.

EMERGENCY MEDICAL CARE

The recipient will be instructed to call your office first in any emergency situation to determine if he or she can be treated in your office. If you cannot treat the recipient in your office you may authorize emergency treatment elsewhere. *However, another provider may provide emergency treatment without your authorization,* for any condition for which a delay in treatment may result in the recipient's death or the permanent impairment of the recipient's health. Once the emergency no longer exists, your authorization is required for nonemergency care.

BILLING

As a primary sponsor you bill the MDSS fee-for-service for the Medicaid-covered services that you provided as explained in the Medical Assistance Program Manual. However, in order to provide timely information to the MDSS for the management reports, claims should be submitted within six months from the date of service. Six months should allow sufficient time to bill other resources (e.g., health insurance, auto insurance).

Special Note:

It is imperative that you inform the following providers of your Medicaid ID Number when you authorize them to provide services to a recipient under your primary care:

- another physician
- a laboratory
- a radiology provider
- a pharmacy
- a hospital provider

These providers must enter your ID Number as the referring physician on their Medicaid claim.

REIMBURSEMENT

As a primary sponsor, regardless of your provider type, you will be reimbursed on a fee-for-service basis for Medicaid-covered services. In addition, you will receive a case management fee of $3.00 per month for each recipient beginning when the recipient(s) is assigned to your care. The case management fee is paid to you each month that the recipient is eligible for Medicaid and assigned to you regardless of whether the recipient was treated by you during the month. Incentives shall also include more equitable reimbursements for ambulatory services and selected surgical procedures when performed in the office setting.

Note: You will be notified by the MDSS prior to the month of service when a recipient is removed from your care. This notification cannot be substituted for reviewing the recipient's Medicaid ID Card to insure he or she is eligible and to determine if there is other insurance coverage for the date that you are providing service.

STANDARDS OF CARE

The MDSS in conjunction with MSMS and MAOP&S will establish specific statistical cost related standards from which to evaluate a sponsor's patterns of utilization and cost for those recipients under his or her care.

The standards will include an item break down and costs per recipient for:

- exams
- laboratory tests
- radiology tests
- prescriptions
- outpatient hospital, including emergency room visits
- inpatient hospital days

Any sponsor who exceeds these standards, in the judgement of the professional societies and the MDSS, will be subject to the following recourses in conjunction with the established peer review committee:

- issued warnings
- have his or her case management fee lowered
- have his or her Medicaid reimbursement for services lowered
- be disenrolled from the Plan

SPONSOR AGREEMENT WITH THE MDSS

If you decide to be a primary sponsor, you will enter into an agreement with the MDSS to participate as a sponsor, and will have the option to renew the agreement at the end of the state's fiscal year, September 30, 1982.

YOUR PARTICIPATION IN THE PLAN

Please seriously consider becoming a primary sponsor. Your participation is needed to make the Plan a success. The Plan guarantees you the continuity of a physician/patient relationship with the Medicaid recipients which you serve. *And savings realized from the Plan are to be shared with you through increases in Medicaid reimbursement.*

APPLICATION INSTRUCTIONS

The application must be completed by the individual physician (i.e., each physician in a clinic or group practice) for the location indicated on the application card. If you practice in more than one location, you must complete an application for *each* location where you wish to be a primary sponsor.

After you complete the application return it to the MDSS. For your convenience, the address has been printed on the card.

Michigan State Medical Society

Michigan Department of Social Services

Michigan Association
of Osteopathic Physicians and Surgeons

DSS PUBLICATION — 415 (11/81)

State Medicaid Information Center
The National Governors' Association
Center for Policy Research

The National Governors' Association, founded in 1908 as the National Governors' Conference, is the instrument through which the governors of the fifty States and the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands collectively influence the development and implementation of national policy and apply creative leadership to state problems. The National Governors' Association membership is organized into eight standing committees on major issues: Agriculture; Criminal Justice and Public Protection; Executive Management and Fiscal Affairs; International Trade and Foreign Relations; Human Resources; Energy and Environment; Community and Economic Development; and Transportation, Commerce, and Technology. Subcommittees that focus on principal concerns of the governors operate within this framework. The Association works closely with the Administration and the Congress on state-federal policy issues from its offices in the Hall of the States in Washington, D.C.

The National Governors' Association Center for Policy Research serves as a vehicle for sharing knowledge of innovative programs among the States and provides technical assistance to governors. The Center also serves governors by undertaking demonstration projects and by providing research and developing policy options on a variety of crucial issues.

The activities and publications of the State Medicaid Information Center are made possible through a grant from the Office of Research and Demonstrations, Health Care Financing Administration. Department of Health and Human Services (HCFA Grant #18-P-97923/3-2).

CMS LIBRARY
3 8095 00014314 5